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Vol. VII No. 1

THE SOCIALIZATION OF MEDICINE

EDITH M. PHELPS, Compiler

THE H.W. WILSON COMPANY
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THE REFERENCE SHELF

Volume VII Number 1

THE SOCIALIZATION OF MEDICINE

SAN FRANCISCO TUBERCULOSIS ASSOCIATION

COMPILED BY
EDITH M. PHELPS

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INTRODUCTION

The socialization of medicine is not a new idea. It exists in fact wherever there is concerted action of physicians, socially minded individuals, organizations or state governments, for prevention and cure of illness. More specifically, it exists today in our Federal, state and local boards of health for the control of the causes and the prevention of the spread of diseases, in our hospitals, free and pay clinics, health centers, convalescent and nursing homes, in our state and national medical organizations with their aims of setting and maintaining standards of training and service, and in voluntary health organizations such, for example, as the National Tuberculosis Association.

A historical survey of medicine reveals two developments worthy of note: 1) medicine has become highly specialized as a result of, or along with, the increasing complexity of our modern civilization; and 2) tremendous progress has been made in new medical discoveries and new methods of caring for the sick. In the last fifty years alone, the use of anesthetics in surgery has become general, and many diseases such as smallpox, yellow fever, and diphtheria have been brought under control. Great improvement has also been made in methods of medical and surgical treatment, and in hospital and nursing care.

With all this advance, however, it is generally conceded that we have not succeeded as yet in making the advantages of modern medicine available to all the people. This is shown, on the one hand, by the great amount of unnecessary sickness that still prevails and, on the other hand, by the growing costs of medical service which already operate to keep a large part of our population, especially the middle class, from its benefits.

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Both of these tendencies are fully recognized and efforts are being made to combat them. Both physicians and public health boards and organizations strive more and more to control the underlying causes of diseases and to spread the desire for health and the knowledge and means for its attainment. The Committee on the Costs of Medical Care was organized especially for the study of this problem, at a conference held in Washington at the time of the annual meeting of the American Medical Association in May, 1927. Headed by Ray Lyman Wilbur, it now consists of forty-five persons, of which fifteen are private practitioners, eleven represent the public, five are economists, and the rest represent the fields of public health work, hospitals, dentistry, nursing and various special interests. Funds have been appropriated for its work by such agencies as the Rockefeller Foundation, the Julius Rosenwald Fund, the Milbank Memorial Fund, the Russell Sage Foundation and the Carnegie Corporation. With this support the Committee undertook a five-year program of studies of the entire subject of medical costs in which the aid was enlisted of many other physicians, economists, social scientists and various groups representing the general public. At the end of three years, several studies have been published and more are in prospect.

To enable medicine to keep pace with the growing needs of civilization, various plans have been suggested, of which "state medicine" is one. Harry H. Moore defines it in his *American Medicine and the People's Health,* as "that form of socialized medicine which is supported by local, state or federal governments." Medical men for the greater part take an attitude of extreme opposition to it, decrying it as "socialistic," "paternalistic," destructive to individualism, private initiative and self-respect. It is objected to often, as are also many other forms of group medicine, as interfering with private medicine. Some physicians resent the increasing extent to which public health has already usurped the field of

preventive medicine, and its tendency to encroach further on the field of curative medicine. On the other hand, there are many physicians and public health officers who feel that, while medicine has become necessarily increasingly specialized, it is not sufficiently organized to attack effectively the problem of public health as a whole; and that state control would be even more desirable in the field of public health than it is in education, state control of which has long been accepted as necessary and desirable for public safety.

Such control as is advised by those arguing for "state medicine" exists as yet only in isolated instances. Perhaps the British control of medicine in India may be a fair illustration of what state medicine might become. The medical service rendered by our Army and Navy to enlisted men has been cited as a pattern for state medicine to follow. Many countries have attempted to provide for public health by creating compulsory or voluntary systems of sickness insurance. The first compulsory system was instituted in Germany by Bismarck in 1883. It has been adopted also in several other countries as Austria, Norway, Russia and many of the smaller countries of Europe. Legislation for voluntary sickness insurance has been adopted in Italy, Sweden, Denmark, Belgium, France, Spain and Switzerland, also in Australia, New Zealand, Canada and the Union of South Africa. An outstanding example is the much-criticized "panel" system of Great Britain. Articles on sickness insurance have been included in the bibliography of this book but the subject has not been covered in the discussion, since space limits forbid.

This number of the Reference Shelf follows the customary arrangement of volumes in the Series, including a selected bibliography, briefs for and against state medicine, and reprints of useful articles arranged as General, Affirmative or Negative. The compiler wishes to thank Miss Marjorie Hutchins, Librarian of the American Medical Association, for the opportunity to examine her

recent bibliography of the subject, and to acknowledge her indebtedness to Miss Margaret Calhoun, formerly of the Cataloging Department of the Library of the College of Physicians and Surgeons of Columbia University, for assistance in examining and securing material for the bibliography; also to Miss Katherine Hayes for her competent assistance in gathering material and handling the many details of editing and proofreading.

E. M. PHELPS

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BRIEF

RESOLVED: *That state medicine should be established.*

INTRODUCTION

I. The term "state medicine" has been defined in various ways.
   A. Harry H. Moore, in his *American Medicine and the People's Health,* calls it
      1. "That form of socialized medicine which is supported by local, state or federal governments."
   B. It was defined by the American Medical Association in a resolution passed at their annual meeting in 1922, as
      1. "Any form of medical treatment provided, conducted, controlled or subsidized by the federal or any state government, or municipality, excepting such service as is provided by the Army, Navy or Public Health Service, and that which is necessary for the control of communicable diseases, the treatment of mental disease, the treatment of the indigent sick, and such other services as may be approved by and administered under the direction of or by a local medical society."
   C. Hugh Cabot, Dean of the Medical School of the University of Michigan, states
      1. "If we understand state medicine to mean progressive assumption on the part of the state of responsibility on health questions such a situation now exists."

II. State medicine should be distinguished from "socialized medicine" or "group medicine."
   A. Harry H. Moore defines socialized medicine as "the science and art of preventing and curing disease through collective effort with the financial support of one or more social groups or governmental units."
   B. "Group medicine" seems to be generally understood as the prevention and cure of disease thru voluntary effort, as opposed to state control.

III. Medicine has become organized to a considerable extent.
   A. A number of agencies have grown up around private medicine, such as hospitals, clinics, drugstores, and private laboratories for diagnosis.
   B. Health departments have been established by many industrial firms to care for their employees.
   C. Many free and pay clinics have been established.
   D. Private organizations for the promotion of health exist in many states, such as the National Tuberculosis Association, visiting nurse societies, and many clinics for prenatal care, infant welfare and venereal diseases.
   E. Standards have been established by the American Medical Association and the American College of Surgeons to improve medical training and practice.

IV. Public health has become a specialized service of itself.
   A. Nearly every state has its health department which controls
      1. Communicable diseases.

2. Collection of vital statistics.
3. The water supply and the disposal of wastes and sewage.
4. Inspection of foods and markets.
5. The dissemination of information about disease.
6. Diagnostic laboratories for the study of disease and public health conditions.

B. There are several Federal agencies for the control of public health.
1. The United States Public Health Service.
2. The National Board of Examiners.
3. Other miscellaneous agencies as the United States Army and Navy medical services.

V. The situation in the medical world has been likened to that of education except that no central agency exists, as in education, to correlate all the work of the various federal, state and private agencies.
A. There exists no unit agency to which a patient may resort to secure a complete diagnosis and treatment of conditions requiring the aid of several departments of medicine.
B. The various agencies are not knit into a single balanced program to provide preventive and curative medicine for the entire community.

VI. It has been claimed that state control of medicine is the only cure for this condition.
A. Opinion is strongly divided as to its advisability.

AFFIRMATIVE

I. There is urgent need for improvement in our existing system of medical service.
A. There persists a large amount of unnecessary illness.

1. It is both the cause and the result of much poverty, crime and delinquency.

B. The prevention and cure of illness have by no means kept up with the great advancement in medical science during the last fifty years.
   1. The use of anesthetics was unknown fifty years ago.
   2. Our theory of the germ as the cause of disease is comparatively new.
   3. Great progress has been made in this time in the discovery and cure of typhoid, yellow fever, small pox and other contagious and infectious diseases.
   4. There has been great progress made in surgery and the care of the sick.

C. The present maladjustment of medical service to public needs is shown by
   1. The inadequacy of both personnel and funds of the various public health agencies.
   2. The shortage of personnel and inacessibility of equipment in private medicine.
   3. The inability of all but the wealthy to pay the costs of medical service.
   4. The resulting resort to such types of medical service, as osteopathy, chiropractic, or cults such as Christian Science.

II. This improvement can only be accomplished by the organization of medicine to fully serve the needs of society.

A. Private medicine has failed to do it.
   1. There is a shortage of physicians.
      a. Many rural communities are entirely without medical service.
      b. Many people in cities find it difficult to get to a good physician in case of need.

c. Doctors are not being graduated from the medical schools in sufficient numbers to keep pace with the growth of population.

2. Medical equipment is insufficient.
   a. Many doctors cannot afford the expensive equipment now necessary for all-round practice in the most up to date manner.
   b. Hospitals, clinics, and convalescent homes exist in inadequate numbers.

3. To some extent the lack of confidence in medical men is justified.
   a. Some doctors are more interested in the fee than the patient.
      (1) They often give insufficient examination.
      (2) They change medicines often when the first fails to bring results.
      (3) They send patients unreasonably from one specialist to another.
      (4) They often fail to provide proper convalescent care.
   b. Physicians are often overtrained.
      (1) They set up as specialists rather than as all-round private practitioners.
      (2) As a consequence, they demand large fees, and often fail to examine patients satisfactorily.
   c. The charge of fee-splitting between physicians seems to have some justification.

4. As a result patients often
   a. Run to the osteopath, the chiropractor, or Christian Science practitioner.
   b. Ask their druggists for remedies.

c. Treat themselves, or take patent medicines.

B. The cost of medical service has assumed alarming proportions.
   1. It is so great that a Committee on the cost of medical care has been established to consider it.
      a. The Committee has been in existence for three years and is still at work.
   2. Adequate medical service can be paid for by only the very wealthy, and is often given to the very poor.
      a. The large middle class must often do without it.
   3. The costs of medical service are due to
      a. The high cost of hospital and nursing service.
         (1) Yet these in themselves are not exorbitant, considering the service and equipment demanded.
            (a) Patients often get better service in hospitals than they would be able to or expect to have at home.
            (b) Hospital buildings are expensive to equip and maintain.
            (c) Nurses do not earn large incomes, altho their charges may seem large to the patient.
      b. The practice of sending patients from one specialist to another.
         (1) Often cases are referred to specialists where there is no need.
      c. The increase in skill and cost of obstetrical practice.

(1) This works a serious hardship on young and growing families.
(a) Yet the service is a necessary one.
(2) In spite of the improvements in obstetrical methods too great a proportion of childbirths are still unattended or taken care of by midwives.
(a) Rankin estimates that 25 to 35 per cent of the childbirth cases are unattended by physicians.

C. Doctors are not fairly paid under the present system.
1. Only a few earn large incomes.
a. Statistics show that charges on the whole are moderate.
2. The reasons for this are
a. The free work given to the poor in hospitals and clinics.
b. The time given to preventive work on boards and public health agencies without remuneration.
c. The expense of training and equipment.

D. The efforts the medical men have made to remedy the situation are insufficient.
1. The voluntary clinics that have been established are too few to do any good.

III. Control of medicine by the state would remedy the matter.

A. The medical service provided every community should
1. Include provision for scientific diagnosis and treatment to all its members in need of medical care.

2. Provide adequate financial remuneration to its physicians.
3. Encourage health education and control spread of disease.
4. Discourage and exterminate the unqualified practitioner.

B. These can be provided by state medicine.
1. It can correlate the work of all the agencies in the community for public and private medicine, and for preventive and curative medicine.
a. These agencies can be utilized to make the benefits of modern medicine available to all people.
2. It can provide some system, such as health insurance, to bring the cost of medicine within the ability of people to pay.

IV. State medicine will have other advantages.
A. For the physician.
I. It can reduce the cost of a medical education.
2. Insure adequate financial compensation to medical men.
3. Raise the general standards of medical practice.
4. Remove competition with the unqualified practitioner by curtailing his activities.
5. Provide access to the needed equipment too expensive for the doctor to purchase for himself.
6. Leave time for those specially qualified for more scientific and medical research.

B. For the patient.
1. It can provide for one examination in one place instead of several.

a. The personal relation between the patient and physician can be retained under this system.

2. Guide him promptly to the best treatment
3. Provide the hospital, nursing and convalescent care needed regardless of his ability to pay.
4. Provide capital outside the medical profession to meet the necessary costs for those unable to pay.

V. State medicine is logical and in keeping with the spirit of the times.

A. We already have it to a considerable degree.

1. In the control of communicable diseases, sanitation, medical care for the men in the army and navy, etc.

B. It is increasing constantly.

1. More and more states and communities are taking over the field of preventive medicine.

C. Medicine is a proper field for state control.

1. It is analogous to education which is now under state control.
   a. It applies even more universally than education.
2. It has many of the aspects of fire and police protection which we consider indispensable to public safety.

D. There is a legal basis for control of medicine by the state.

1. The state has certain police powers which aim at protection of national existence, maintenance of right or justice and the public welfare.
   a. Public health is an important factor in public safety.

NEGATIVE

I. The idea that better medical service for all people can only be attained thru control by the state or group is open to several fallacies.
   A. That all patients who consult doctors need exhaustive examination to find out what is the matter with them.
      1. The majority of cases are simple, easily diagnosed by the general practitioner.
   B. That group medicine would respond to all calls satisfactorily.
      1. It is doubtful whether night or emergency calls would be handled as satisfactorily by the clinic as by the family doctor.
   C. That modern medical skill can solve all problems of disease.
      1. So much depends upon the personality of the patient, which often can be learned only by long acquaintance.
      2. Clinics are as apt to err in diagnosis and treatment as the single physician.
   D. That people can organize for the production of personal services the same as for the production of goods.

II. The mechanization of medicine which would result from state control would be a menace to sound medical practice.
   A. For the patient.
      1. It would interfere with the right of the individual to choose his own medical service.
      2. It would interfere with the intimate and personal relationship of doctor and patient which is necessary for complete relief from patient's ills.

3. The periodic health examination is not satisfactory when given on an impersonal basis.
   a. While it may detect symptoms of incipient disease, it does not get at the personality of the patient.
      (1) Even the best social service technique may fail to find it.

B. For the doctor.
   1. It would interfere with the work of the general practitioner.
      a. This is already being cut in on by the various health agencies and free clinics which are taking over more and more the domain of curative medicine.
   2. It would mean inadequate compensation for doctors.
      a. The average salary of a doctor in state or commission organizations is now from $3000 to $4000 a year.
         (1) His education alone may have cost him from $20,000 to $25,000.
   3. It would lower standards of practice.
      a. Patients would be moved along too fast.
         (1) The temptation would be for the doctor to see as many as possible.
      b. The doctor would tend to get into a routine.
         (1) This would mean loss of initiative and individuality.
      c. He would depend upon wire-pulling for promotion rather than individual improvement.

d. It would threaten to curtail the domiciliary visit which is necessary to the success and permanency of the family physician.

4. It would tend to throttle medical progress.
   a. There would not be the same incentive to make new discoveries and carry on research.
5. Doctors can only maintain the highest point of efficiency and service by preserving their individualism.

C. For the public.
1. The expenditure of money and labor would often be out of proportion to the benefits rendered.
2. To much centralization of government is dangerous.
   a. It undermines people's self-respect.
   b. It leaves to government bureaucrats what should be done by private initiative.

III. There are other reasons why state medicine is undesirable.

A. It is but another step in the existing "pauperization" of medicine.
1. The trend is already too far in this direction.
   a. General practitioners already have to compete with the state, city and county departments of health.
   b. They also have to compete with many medical boards, bureaus and clinics where medical service is given at little or no cost.
   c. They must compete with hospitals, free clinics, university and social center clinics, etc.

2. Physicians should be fully compensated for their services.
    a. Patients should be under no obligations to doctors or hospitals.

B. Industrial medicine has often become only an instrument for fighting claims for compensation.
    1. The services offered are often so impersonal that workers prefer their own physicians.
    2. It is better to give workers adequate compensation so that they may provide for their own medical care.

C. Group clinics are often unsuccessful.
    1. They often involve expense, time and labor out of proportion to the benefits gained.
    2. They are deadening to the self-respect of the patient.
    3. They savor of department store methods.
    4. Groups of physicians may sometimes organize for monopolization of practice.
    5. Doctors have little organizing talent.
    6. Group clinics tend to disintegrate and have a short life.

D. The socialization of medicine is against nature's law of the survival of the fittest.
    1. It is an attempt to interfere with the removal of the unfit by disease.

E. More and more the influence of the mind on disease and its treatment is being recognized.
    1. State medicine would prevent the advancement of this recognition.

F. The medical profession, perhaps more than any other, is devoted to public service at its own expense.

1. It is engaged in combatting the very thing on which its livelihood depends.
2. State medicine would tend to destroy this humanitarianism by removing personal responsibility.

IV. State medicine has not been successful in other countries where it has been tried.
   A. It has been declared that in Germany it tends to make people morbidly interested in their physical progress.
      1. They demand the time and attention of doctors unnecessarily.
   B. The panel system has been declared a failure in England.
      1. It has failed to bring the benefits of medicine to the people.
         a. Panel practitioners have not been able to have the use of hospitals and other facilities freely for treatment of their patients.
   C. Physicians in Belgium complain that they can no longer get a sufficient number of patients to earn a livelihood for themselves and their families.

V. Physicians themselves do not favor it.
   A. The American Medical Association has gone on record against it.
   B. Many state medical associations have declared themselves against it in their annual meetings.
   C. Eminent men in the medical profession have spoken against it, including, among others,
      1. Morris Fishbein, editor of the Journal of the American Medical Association.
      2. William G. Morgan, president of the American Medical Association.

3. William Mayo, of the well-known Mayo Clinic, one of the largest and best-known group clinics in this country.

D. At the same time, these men realize that for relief from the present inadequacy of medical practice, some form of organization is necessary.
   1. They agree generally that some form of group medicine should be undertaken by the medical profession itself.

BIBLIOGRAPHY

An asterisk (*) preceding a reference indicates that the article or a part of it has been reprinted in this volume.

Bibliographies

American Medical Association. Bibliography on state medicine. 22p. mimeo. O. 31, '30.

Badcock, Mabel A. comp. Cost of medical care: a selected bibliography. 4p. pa. (Russell Sage Foundation Library Bulletin. No. 103. O. '30)

Committee on the Cost of Medical Care. First two years' work, July 1927-June, 1929. p. 21-3. List of some recent magazine articles. . . 910 17th St. N.W. Wash. D.C. '29.

Leigh, Robert D. Public health administration in the United States. bibliog. p. 627-68. Harper. N.Y. '27.

Moore, Harry H. American medicine and the people's health. 647p. D. Appleton & Co. N.Y. '27.

Short bibliographies are appended to most of the chapters.

Moore, Harry H. Public health in the United States. bibliog. p. 518-20. Harper. N.Y. '23.

General References

Books and Pamphlets

Bolt, Richard Arthur. Cost of obstetric service to Berkeley mothers, 15p. pa. Committee on the Costs of Medical Care. Wash. D.C. '30.

Reprinted from the Journal of the American Medical Association. 94:1561-5. May 17, 1930.

Bryant, L. F. Better doctoring, less dependency. 90p. gratis. Associated Out-Patient Clinic Committee. 244 Madison Av. N.Y. '27.

Carpenter, Niles and others. Medical care for 15,000 workers and their families. Pub. No. 5. Committee on the Costs of Medical Care. Wash. D.C. '30.

A survey of the Endicott Johnson Workers Medical Service: 1928. See also abstract of this publication. 24p. pa. '30.

Committee on the Cost of Medical Care. First two years' work, July 1927-June 1929. 23p. pa. gratis. 910 17th St. N.W. Wash. D.C. '29.

Dunham, F. L. Approach to social medicine. 242p. $4. Williams & Wilkins. Baltimore. '25.

*Frankel, Lee K. Cost of Medical care. 11p. pa. Committee on the Cost of Medical Care. 910 17th St. N.W. Wash. D.C. '30.

Includes some tables of statistics collected by the Metropolitan Life Insurance Co.

Leigh, Robert D. Federal health administration in the United States. 687p. Harper. N.Y. '27.

Mayers, Lewis and Harrison, Leonard V. Distribution of physicians in the United States. xii,197p. General Education Board. N.Y. '24.

Medical care of industrial workers. 112p. National Industrial Conference Board, Inc. N.Y. '26.

Moore, Harry H. American medicine and the people's health. 647p. D. Appleton & Co. N.Y. '27.

An excellent impartial study of the entire question of the socialization of medicine. Bibliographies are appended to most of the chapters.

Moore, Harry H. Public health in the United States. xxii,557p. Harper. N.Y. '23.

See p. 380-9. Socialization of curative medicine.

Peebles, Allon. A survey of statistical data on medical facilities in the United States. 119p. (Committee on Cost of Medical Care, pub. no. 3) 910 17th St. N.W. Wash. D.C. '29.

*There is also an abstract of this article covering 19 pages.

Whiteside, G. W. Relation of the medical man to the public. 21p. Edward E. Hicks, Cor. Sec. Society of medical jurisprudence, 1168 Dean St. Brooklyn, N.Y. '21.

Wilbur, Ray Lyman. The first three years' work of the Committee on the costs of medical care and its plan for the future. 10p. Committee on the Cost of Medical Care. 910 17th St. N.W. Wash. D.C. '30.

PERIODICALS

American Journal of Public Health. 10:969-72. D. '20. Meaning and purpose of socializing medicine. Ira S. Wile.

American Journal of Public Health. 13:638-41. Ag. '23. Report of the Committee on medical service of the state and provincial health authorities. Matthias Nicoll, jr.

American Journal of Public Health. 16:369-74. Ap. '26. Health department and free service.

A discussion of the extent to which free service can be given without encroaching on the legitimate field of the private practitioner.

*American Journal of Public Health. 19:359-65. Ap. '29. The economics of medical service. W. S. Rankin.

*American Journal of Public Health. 20:882. Ag. '30. Obstetric costs. R. A. Bolt.

An abstract of article appearing in the Journal of the American Medical Association. 94:1561-5. May 17, 1930.

American Labor Legislation Review. 18:171-80. Je. '28. The high cost of being sick. Michael M. Davis.

Stresses especially the "uneven incidence of sickness." With table.

American Mercury. 75:275-81. N. '28. Hospitals. Chester T. Crowell.

Discusses hospital mismanagement especially in childbirth cases.

Atlantic Monthly. 135:586-94. My. '25. High cost of babies. Ida L. Albright.

Atlantic Monthly. 140:460-5. O. '27. The cost of illness. Anne Miller Downes.

Atlantic Monthly. 144:838-47. D. '29. Formosa, Japan's experiment; conquest of Taiwan by medicine. K. K. Kawakami.

Describes Japan's policy of "state medicine" in Formosa.

Atlantic Monthly. 145:732-40. Je. '30. How necessary is illness? Ralph A. Reynolds.

Describes how medicine is "socialized" in Vienna and Russia.

Boston Medical and Surgical Journal. 187:53-65. Jl. 13, '22. Quackery, miracle healing and medical cults [with references]. Robert W. Lovett.

California State Journal of Medicine. 19:245-8. Je. '21. Organized medicine for masses a feature of present day medical practice. E. W. Cleary.

Century. 104:416-26, 593-601, 781-9, 950-6. Jl.-O. '22. Our medicine-men, by one of them.

Colorado Medicine. 23:230-2. Jl. '26. Private practice and state medicine. H. Sewall.

Contemporary Review. 121:364-72. Mr. '22. Problem of medical services. J. Middleton Martin.

*Family. 11:162-7. Jl. '30. The financing of medical care as a problem in family economy. Niles Carpenter and others.

Forecast. 38:143-4. S. '29. The Committee on cost of medical care. E. H. Wharton.

Forum. 82:22-8. Jl. '29. Doctors and the public. Francis Graham Crookshank.

Favors group medicine thru public hospitals but not state medical service.

Harper's Magazine. 148:303-14. F. '24. New control of surgeons. William G. Shepherd.

Laments the number of unnecessary surgical operations performed and shows how this is being gradually corrected.

Harper's Magazine. 153:735-41. N. '26. Economics of world health. Louis N. Dublin.

Harper's Magazine. 157:614-21. O. '28. Mammon, M.D. Lloyd Morris.

*Harpers' Magazine. 158:50-6. December, 1928. A family doctor speaks his mind. Wingate M. Johnson.

*Hospital Management. 21:58-9. My. '26. Medical service in industry making great strides. M. W. Alexander.

Hospital Social Service. 8:8-21. Jl. '23. Objections to pay clinics. Louis I. Harris.

Hospital Social Service. 8:22-9. Jl. '23. Pay clinics. Michael M. Davis, jr.

Hygeia. 8:815-17. S. '30. How Cleveland guards the health of its children. P. L. Riley.

Describes the work of Cleveland's public school health service.

Independent. 121:255-7+. S. 15, '28. The patient pays the piper. Joseph Garland.

International Clinics. Vol. II, Ser. 38:292-302. Je. '28. The economic basis of medical charges. Michael M. Davis.

International Journal of Public Health. 1:58-64. Jl. '20. Definition and scope of social medicine. Gùiseppe Troperro.

Journal of the American Medical Association. 76:1055-62. Ap. 16, '21. Adequate medical service for a community. W. H. Smith.

Journal of the American Medical Association. 76:1083-7. Ap. 16, '21. Hospital service in the United States.

This takes into account 5,013 general service hospitals, which include virtually all except federal and state institutions and hospitals for nervous and mental cases.

Journal of the American Medical Association. 80:1932. Je. 30, '23. Survey of group clinics.

From report of the Council on Medical Education and Hospitals.

Journal of the American Medical Association. 81:1427-9. O. 27, '23. Growing importance of preventive medicine to the general practitioner. John M. Dodson.

*Journal of the American Medical Association. 85: 585-94. Ag. 22, '25. Annual presentation data for 1925 by the Council on medical education and hospitals.

Journal of the American Medical Association. 86:1644-5. My. 22, '26. Is universal life insurance coming? W. E. Musgrave.

Journal of the American Medical Association. 89:2012-15. D. 10, '27. Gynecology and foreign governments. F. C. Holden.

Journal of the American Medical Association. 90: 781. Mr. 10, '23. More about state medicine.

Journal of the American Medical Association. 90:1897-1902. Je. 9. '28. Some tendencies in business of practice of medicine. W. A. Pusey.

Journal of the American Medical Association. 92: 1410-12. Ap. 27, '29. Relationship of medical education to the cost of medical care. Ray Lyman Wilbur.

*Journal of the American Medical Association. 94: 2035-42. Je. 28, '30. Medical profession and paternalistic tendencies of the times; president's address. W. G. Morgan.

General discussion of development of state medicine, defining and discussing the *term;* and giving statisics on cost of medical service.

Journal of the Indiana State Medical Association. 22: 317-21. Ag. '29. State medicine or what? M. A. Austin.

Journal of the Kansas Medical Society. 29:247-51. Ag. '28. State medicine. C. H. Lerrigo.

Journal of the Michigan State Medical Society. 26:435-9. Jl. '27. Medical legislation. J. J. Jackson.

Ladies' Home Journal. 40:23+. O. '23. Vanishing country doctor. Samuel Hopkins Adams.

Describes shortage of doctors in rural communities.

Ladies' Home Journal. 47:16-17+. O. '30. High cost of being sick. Frederick L. Collins.

Literary Digest. 97:17. Je. 30, '28. The high cost of health.

Describes the aims of the then newly organized Committee on the Cost of Medical Care.

Literary Digest. 103:28+. N. 9, '29. A thrust at high medical charges.

Some expert opinions on how these charges can be lowered.

Literary Digest. 106:28. Jl. 19, '30. To cut the "high cost of health."

Discusses the measures proposed by the American Medical Association to ward off state medicine.

Modern Medicine. 2:776-9. N. '20. The state and future of medical practice. George Newman.

Describes growth of state medical treatment in Europe.

Monthly Labor Review. 26:885-8. My. '28. Cost of medical service. [tables]

Monthly Labor Review. 31:611-12. S. '30. Cost of medical care.

Nation. 128:502-3. Ap. 24, '29. Shall doctors' fees be lowered? Frederic Babcock.

National Conference of Social Work. Proceedings. 1919:186-90. How far does the American family budget provide for necessary medical and social care? Lee K. Frankel.

National Conference of Social Work. Proceedings. 1919:190-4. Health insurance as a means of providing medical care. John A. Lapp.

National Conference of Social Work. Proceedings. 1923:56-64. Growth of the social point of view. William F. Snow and others.

*National Conference of Social Work. Proceedings. 1928:213-17. Child health versus the pocket book. Michael M. Davis.

Nebraska State Medical Journal. 15:217-20. Je. '30. High cost of medical care and state medicine; presidential address. K. S. J. Hohlen.

New England Journal of Medicine. 200:1161-3. My. 30, '29. Sickness insurance in Germany and Austria. C.-E. A. Winslow.

New Republic. 48:249-50. Ap. 17, '29. Odyssey of a sick man. Philip Wagner.

New Republic. 49:60-1. Je. 5, '29. The cost of medical care.

New York City. Dept. of Health. Monthly Bulletin. 11: 293-308. D. '21. Remedies for certain defects in medical organization and service. L. I. Harris.

New York State Journal of Medicine. 21:189-94. Je. '21. The future of medicine in America. Lewellys F. Barker.

*Nineteenth Century. 104:583-94. N. '28. National health insurance. E. G. Little.

Describes the working of the English law for government medical service and its drawbacks.

North American Review. 226:390-8. O. '28. The high cost of doctoring. T. Swann Harding.

*North American Review. 227:89-94. Ja. '29. The swan song of the country doctor. A. F. van Bibber.

Laments scarcity of country doctors. This due to stringent requirements and small recompense.

North American Review. 227:493-8. Ap. '29. They shall not pass. Karl W. Detzer.

Denies the passing of the country doctor.

Ohio State Medical Journal. 24:610. Ag. '28. Government benefits.

A discussion of government aid to Veterans and the attitude of the American Medical Association toward it.

Ohio State Medical Journal. 24:938-9. D. '28. Medicine in government service.

Ohio State Medical Journal. 25:725-30. S. '29. Socialized medicine as part of a program of social insurance—data and comparison in France and Germany. tr. by L. L. Bigelow.

Plain Talk. 4:673-8. Je. '29. Do doctors charge too much? Harold E. Hullsiek.

Review of Reviews. 61:664-5. Je. '20. Medical service for isolated communities.

Review of Reviews. 64:555. N. '21. Medical specialists in Council; group medicine.

Largely an abstract of article by Mary E. Jamieson in the Scientific American.

Science. n.s. 56:405-9. O. 13, '22. Whither? M. H. Fischer.

Criticises the training of physicians and urges need for them to be alive to the social trend in medical service.

Science. n.s. 68:189-92. Ag. 31, '28. Forgotten physician. S. W. Lambert.

Scientific American. 125:201+. S. 17, '21. Group medicine. Mary E. Jamieson.

Survey. 43:357-62. Ja. 3, '20. Increasing socialization of medicine. Sir Arthur Newsholme.

Describes the progress of the socialization of medicine in England.

Survey. 44:707. S. 15, '20. What the doctors must do. D. B. and E. B. Armstrong.

Survey. 49:794-6. Mr. 15, '23. Who's to pay the doctor? Anna King.

Describes the work of the Cornell Clinic and the Buffalo Department of Hospitals and Dispensaries.

Survey. 55:409-11. Ja. 1, '26. Doctor and the changing order. George E. Vincent.

Survey. 59:119-22. N. 1, '27. When sickness hits the pocketbook. Michael M. Davis.

Survey. 59:435-8+. Ja. 1, '28. The blunderbuss of sickness. Michael M. Davis.

Survey. 59:565-7. F. 1, '28. Sickness bills and the sliding scale. Michael M. Davis.

Survey. 60:541-3+. S. 1, '28. How pay sickness bills? Michael M. Davis.

Survey. 62:227-8. My. 15, '29. Where doctors racketeer. Mary Ross.

Survey. 63:402-4+. Ja. 1, '30. Pioneers plough a way. C. P. Streeter.

*Survey Graphic. 63. no. 7. Ja. 1. '30. How shall the doctor be paid?

The entire number is given over to this subject. There are sixteen articles by men of eminence in the fields of medicine and public health.

Woman's Home Companion. 49:12+. Ag. '22. Teamwork for health. T. H. Halsted.

Yale Journal of Biology and Medicine. 1:391-402. Jl. '29. Sickness insurance in Central Europe and its lessons for us in the United States. C.-E. A. Winslow.

Affirmative References

*American Journal of Public Health. 10:921-31. D. '20. Social uses of medicine. D. B. Armstrong.

American Journal of Sociology. 34:507-15. N. '28. Medicine's greatest problem: the need of state medicine. G. W. Haigh.

American Medical Association Bulletin. 18:443-8. D. '23. Group medicine in practice. Rexwold Brown.

Boston Medical and Surgical Journal. 184:563, 570-2. Je. 2, '21. Some of the mutual relations between physician and commonwealth. F. W. Anthony.

Boston Medical and Surgical Journal. 192:1162-4. Je. 11, '25. How medicine can best serve. G. W. Haigh.

Boston Medical and Surgical Journal. 196:973-83. Je. 16, '27. "Group practice." Philemon E. Truesdale.

British Medical Journal. Sup: 165-7. O. 12, '29. Local government and medicine: presidential address. A. B. McMaster.

Canadian Medical Association Journal. 21:168-72. Ag. '29. An address on sickness insurance. J. W. S. McCullough.

*Century Magazine. 102:953-60. O. '21. Trailing the Robin Hoods of medicine. Glenn Frank.

Proposing national control of medicine as a remedy for existing evils.

Colorado Medicine. 17:288-94. N. '20. State medicine. What is it and in what directions should it be developed? V. C. Vaughan.

Co-operative Review. No. 11:170-5. S. '28. A co-operative medical service. N. J. Norton.

Forum. 81:345-51. Je. '29. How scientific are our doctors? T. Swann Harding.

SAN FRANCISCO PUBLIC

Frankel, Lee K. Future of medical practice. 8p. pa. Metropolitan Life Insurance Co. N.Y. '30.

Address delivered at dedication of the West End Health Center, Boston, Mass. September 15, 1930.

*Harpers' Magazine. 155:767-76. N. '27. What price doctors? Louis I. Dublin.

Upholds "group or team medicine" and "sickness insurance" as cure for high cost of medicine—neither unfavorable to doctor's finances.

Harper's Magazine. 161:710-19. N. '30. A patient looks at doctors.

Harvard Graduates Magazine. 36:506-14. Je. '28. Reformation of medicine. G. W. Haigh.

Industrial and Labour Information. 34:375-80. Jl. 9, '30. Proposals for a general medical service in Great Britain.

Journal of the American Medical Association. 62:821-3. Mr. 14, '14. Medicine a function of the state. Arthur D. Bevan.

Journal of the American Medical Association. 63:264-6. Jl. 18, '14. Socialization of medicine. James P Warbasse.

Journal of the American Medical Association. 76:1308-12, 1350-3, 1397-403. My. 7, 14, 21, '21. National health insurance. Alfred Cox.

Journal of the American Medical Association. 79:281-3. Jl. 22, '22. The mutual interest of the profession and the public. W. S. Rankin.

Journal of the American Medical Association. 79:1541-2. O. 28, '22. The rural physician in Ohio. C. E. Lively.

Journal of the American Medical Association. 86:419-20. F. 6, '26. The physician of the future.

Journal of the American Medical Association. 93:1022. S. 28, '29. Sickness insurance

Journal of the American Medical Association. 94:879. Mr. 22, '30. A new form of medical socialism.

Plans for forming a "public medical service association" to establish a medical service available to all people.

Journal of the American Medical Association. 94:1612. My. 17, '30. A national medical service: extension of medical socialism.

Journal of the American Medical Association 95:543-4. Ag. 16, '30. A deeper plunge into medical socialism.

Journal of the Medical Society of New Jersey. 24:731-6, 740-1. D. '27. Control of private hospitals. J. Bennett Morrison.

Journal of the Medical Society of New Jersey. 26:693-7. O. '29. State medicine; boon or bogy? G. W. Haigh.

Definition of term, state medicine, and good outline of plan for control of medicine by the government.

Lancet. 1:1226-9. Je. 16, '23. Panel conference: revision of terms of service.

Medical Record. 100:143-9. Jl. 23, '21. Concerning the health problem. F. E. Jackson.

Modern Medicine. 1:98-108. Je. '19. Group medicine. A. J. Barker Savage.

Nation. 123:398-400. O. 20, '26. Socialization of medicine. J. Krimsky.

*Nation. 126:508-10. My. 2, '28. In defense of socialized medicine, reply to M. Fishbein. I. M. Rubinow.

New England Journal of Medicine. 202:1075-6. My. 29, '30. State medicine.

Describes proposed legislation in Massachusetts for state control of medicine.

New England Journal of Medicine. 202:1078-83. My. 29, '30. In defense of state medicine; address before legislative committee. G. W. Haigh.

Good outline of government control of medicine with statements of benefis to be derived from it.

*North American Review. 227:193-200. F. '29. State medicine: boon or bogy? G. W. Haigh.

*North American Review. 228:57-64. Jl. '29. Are hospital costs too high? Cleon C. Mason.

Northwest Medicine. 18:197-8. O. '19. Some problems facing organized medicine. H. P. Marshall.

Ohio State Medical Journal. 12:98-101. F. '16. State medicine. C. O. Probst.

Ohio State Medical Journal. 25:817-18. O. '29. Status of "state medicine" in other countries and proposal for development in America thru federal departments.

Ohio State Medical Journal. 25:866-7. N. '29. Significant experiment in social medicine.

Pennsylvania Medical Journal. 32:299-301. Ja. '29. Functions of state department of welfare. E. H. McCauley.

Public Health Service Bulletin. no. 99:103-6. '19. Studies of medical and surgical care of industrial workers. C. D. Selby.

Review of Reviews. 78:211-13. Ag. '28. Reformation of medicine.

An abstract of article by G. W. Haigh in the Harvard Graduates Magazine.

Saturday Evening Post. 197:12-13, 135, 137-8, 141. O. 4, '24. Choosing your doctor. Woods Hutchinson.

*Scientific Monthly. 11:235-45. S. '20. Medical and allied profession as a state service. D. Fraser Harris.

Survey. 44:663. S. 1, '20. Physician objects. D. B. Armstrong and E. B. Armstrong.

Survey. 60:165-7+. My 1, '28. The doctor's kit of tools. Michael M. Davis.

Texas State Journal of Medicine. 16:375-7. Ja. '21. State medicine and public hygiene. C. W. Goddard.

Woman's Home Companion. 49:17-18. S. '22. Right to good health. T. H. Halsted.

Negative References

American Journal of Public Health. 13:1-5. Ja. '23. Health officer's challenge to the general practitioner. James D. Robertson.

American Medical Association Bulletin. 23:55-61. F. '28. Federal, medical and surgical relief for diseases and injuries of civil life. W. C. Woodward.

SAN FRANCISCO TUBERCULOSIS ASSOCIATION

Anderson, H. B. State medicine a menace to democracy. 115p. $1. Citizens Medical Reference Bureau, 145 W. 45th St. Brooklyn, N.Y. '20. [tables].

Atlantic Monthly. 146:529-37. O. '30. A cure for doctor's bills. Evans Clark.

Evans Clark is director of the Twentieth Century Fund founded by E. A. Filene of Boston.

Boston Medical and Surgical Journal. 182:595-601. Je. 10, '20. Compulsory health insurance, state medicine or what? Hugh Cabot.

Represented in Modern Medicine. 2:533-8. August, 1920.

Catholic Charities Review. 13:145-7. My. '29. Who should bear the cost of hospital and medical care for the American wage earner? A. M. Schwitalla.

Commonweal. 12:274. Jl. 9, '30. Substitutes for socialization.

Discusses policy of "Voluntary Collectivism" advocated by the American Medical Association at the Detroit meeting.

Contemporary Review. 115:437-43. Ap. '19. The future of medicine. James Mackenzie.

Illinois Medical Journal. 40:1. Jl. '21. Personal experience with state medicine in Germany. E. Ries.

*Illinois Medical Journal. 40:278-81. O. '21. Paternalism destroys self reliance; state medicine a menace to people. W. D. Chapman.

Illinois Medical Journal. 54:151-6. Ag. '28. Private practice is at stake. P. R. Blodgett.

Illinois Medical Journal. 56:247-54. O. '29. State medicine means regimentation and nullity. C. B. Reed.

A strong article against control of medical matters except by medical men; taking up also medical economics and cost of medical care.

Journal of the American Medical Association. 74:1319. My. 8, '20. Report of Reference committee on hygiene and public health on compulsory sickness insurance.

Journal of the American Medical Association. 76:921-5. Ap. 2, '21. Medical profession and the public. William J. Mayo.

Journal of the American Medical Association. 76:1477-83. My. 28, '21. Social responsibilities of modern medicine. F. R. Green.

Journal of the American Medical Association. 76:1682. Je. 11, '21. Resolution on state medicine.

*Journal of the American Medical Association. 79:513-16. Ag. 12, '22. Socialistic tendencies in medicine. James A. Gardner.

Journal of the American Medical Association. 82: 1905-8. Je. 14, '24. Some of the social problems of medicine: Address of Pres.-elect William Allen Pusey.

*See also p. 1960-4. The trend in medical and nursing services.

Journal of the American Medical Association. 86:1840. Je. 12, '26. Federalized medical treatment versus private practitioner.

Journal of the American Medical Association. 87:1481-2. O. 30, '26. The physician of the future.

Journal of the American Medical Association. 92: 1350-2. Ap. 20, '29. The Chicago Public Health Institute has a newspaper holiday.

*Journal of the American Medical Association. 94: 2070-1. Je. 28, '30. Address of President. M. L. Harris.

Discussion of undesirability of state medical service and the harm it would cause; telling also of the establishment of a Committee on Cost of Medical Care and its three fundamental aims.

Journal of the American Medical Association. 95:1266-7. O. 25, '30. The cost of medical care.

Journal of the Indiana Medical Association. 14:371-4. N. '21. Medicine and state control. David Ross.

Journal of the Indiana Medical Association. 15:117-22. Ap. '22. State medicine. C. S. Bosenbury.

Journal of the Iowa Medical Society. 11:417-21. N. 15, '21. Organization or association of physicians as against individualism or socialization. C. B. Taylor.

Journal of the Michigan State Medical Society. 20:225-31. Je. '21. Existing relation between medical profession and the public and future tendency. A. McLean.

*Journal of the Michigan State Medical Society. 20:489. N. '21. Letter from Dr. S. E. Barnett.

Journal of the Michigan State Medical Society. 20:510-14. D. '21. Group medicine or state medicine. A. W. Blain.

Journal of the Michigan State Medical Society. 26:491-500. Ag. '27. Socialization and paternalism in medical practice. M. Fishbein.

Journal of the Missouri Medical Association. 20:66-8. F. '23. Some problems in rural health service and state medicine. F. C. Nifong.

Kentucky Medical Journal. 18:185. Je. '20. Tendency toward state medicine. W. W. Anderson.

Lancet. 1:111-13. Ja. 11, '30. Point of view of panel doctor. H. Roberts.

Lancet. 1:344-6. Mr. 2, '18. The ministry of health. A. M. Fraser.

Medical Record. 99:521-2. Mr. 26, '21. Pauperizing the public. G. L. Servoss.

Minnesota Municipalities. 15:55-8. F. '30. The cost of medical care. O. E. Locken.

*Nation. 126:484-6. Ap. 25, '28. Socialized medicine. Morris Fishbein.

Nebraska Medical Journal. 14:483-7. D. '29. State medicine. P. Findley.

New England Journal of Medicine. 200:438-9. F. 28, '29. Is the state's cancer program state medicine? G. H. Bigelow.

Northwest Medicine. 23:387-8. S. '24. Can organized profession prevent state medicine and unjust federal taxation? R. C. Monahan.

Ohio State Medical Journal. 22:606-10. Jl. '26. Social and economic problems affecting medical practice. L. L. Bigelow.

Ohio State Medical Journal. 22:778-82. S. '26. Relationship of department of health to practice of medicine. C. W. Waggoner.

Ohio State Medical Journal. 23:46-9. Ja. '27. Relationship between public health and medical practice. L. G. Bowers.

Ohio State Medical Journal. 23:62-3. Ja. '27. Some comments and comparisons on the multiple problems and deterioration of medical service under England's "state medical system."

Ohio State Medical Journal. 24:18. Ja. '28. A socialistic experiment.

Ohio State Medical Journal. 24:609-10. Ag. '28. Comment on the English system.

Gives reasons why the English panel system has not been a success.

Ohio State Medical Journal. 25:120-1. F. '29. Social insurance abroad and the attitude of the French medical association. tr. by L. L. Bigelow.

Describes the abuses of the state medical system in Germany and what might happen in France.

Ohio State Medical Journal. 25:443-4. Je. '29. Business view on paternalism.

Foresees the Sheppard-Tower Act as a beginning of a general system of federal government medicine.

Ohio State Medical Journal. 25:619. Ag. '29. A comment on public medicine.

Ohio State Medical Journal. 26:613-14. Jl. '30. Social and welfare theories of government are involved in legislative program of non-service disabilities.

Outlook and Independent. 152:221. Je. 5, '29. Doctors or robot menders? Morris Fishbein.

Trained Nurse. 84:669-70. My. '30. How may the cost of medical care be financed by the average family? [tables]

DEFINITIONS

If. . .we understand this somewhat loose phrase (state medicine) to mean progressive assumption on the part of the state of responsibility of health questions, such a situation now exists.—*Hugh Cabot, Dean of the Medical School of the University of Michigan. Boston Medical and Surgical Journal. Je.* 10, '20. *p.* 597.

Social medicine is a science which designs to coordinate and popularize the scientific and practical results of the customs and laws of peoples and governments with the object of protecting the physical, moral and economic life of nations by diminishing disease and mortality, by prolonging the average period of life of the poorer classes and by the betterment of the race.—*Guiseppe Troperro in the International Journal of Public Health. Jl.* '20. *p.* 58-64.

"State medicine" is hereby defined for the purpose of this resolution to be any form of medical treatment, provided, conducted, controlled, or subsidized by the federal or any state government, or municipality, excepting such service as is provided by the Army, Navy or Public Health Service, and that which is necessary for the control of communicable disease, the treatment of mental disease, the treatment of the indigent sick, and such other services as may be approved by and administered under the direction of or by a local county medical society of which it is a component part.—*Resolution passed by the American Medical Association at its annual meeting in* 1922.

It is perhaps desirable to attempt at this stage a definition of the sense in which I employ the term social-

ization of medicine. In it I would include the rendering available for every member of the community, irrespective of any necessary relation to the ordinary conditions of individual payment, of all the potentialities of preventive and curative medicine. Within the scope of medicine are included the basic sciences of physiology and pathology; and the instruction and training of every child and young person in elementary hygiene, including dietetics, necessarily come also within the range of our subject.—*Sir Arthur Newsholme. Survey. Ja. '20. p.* 357.

In its broader sense the study of hygiene includes the examination of the conditions which affect the generation, development, growth and decay of individuals, of nations, and of races, being on its scientific side coextensive with biology in its broadest sense, including sociology, rather than with physiology and merely, as some writers state. . . The term state medicine is broader than public hygiene since the latter includes the former, together with legal medicine, medical education, and all subjects which treat of the relation of the physician to the state.—*Dr. Samuel W. Abbott, Sec. State Board of Health of Mass. From "The Past and Present Condition of Public Hygiene and State Medicine in the United States." (Monographs on American Social Economics. ed. by H. Adams)* 1900. *no.* XIX. *p.* 5, 6.

Two attempts have been made at clarifying the term "state medicine" which may be profitably observed. In response to the question, "What is the real essence of state medicine stripped of its paraphernalia?" Dr. G. S. Luckett suggested at the 1922 annual session of the New Mexico Medical Society, "is it not fundamentally the application of the simple proposition that 'every benefit of the art and science of medicine should be made available to *all* the people'? It is simple, when we look at it that way, and a doctrine to which we can all subscribe. What we really fear about it is not the principle but the

mode of application." A committee of the Massachusetts Department of Public Health presented in November, 1924, a report on *Health and Medical Service in Sparsely Settled Districts* and found it necessary to propose a definition of the term "state medicine" for use in that report. As the term is used by this committee, state medicine is "medical serice to the individual at the expense of the community."

. . .Based on the generally accepted meanings of the words "state," "socialized," and "medicine," state medicine is merely medicine controlled by the state; and socialized medicine is medicine controlled by any social group. There is no logical ground for calling one form of medicine controlled by the state "public health work" and calling another kind "state medicine." The medical schools of some years ago which called occasional lectures on public health work lectures on state medicine, were right. Public health work is quite properly included in state medicine.

Is it not evident, then, that, from the standpoint of political science and sociology, *socialized (or social) medicine*, as contrasted with the private practice of medicine, is the science and art of preventing and curing disease through collective effort with the financial support of one or more social groups or government units? And is it not clear that *state medicine* is merely that form of socialized medicine which is supported and directed by local, state, or federal government?—*Harry H. Moore in "American Medicine and the People's Health." p.* 452-4.

GENERAL DISCUSSION

FACTS TO FACE THE FUTURE[1]

Society organizes itself slowly and with great waste of human effort and wealth. The slow processes of our changing social order operate constantly. Those who are trying to accelerate or to guide them find themselves in a labyrinth of opinion, tradition, habit, stubbornness, finance and widely varying view-points. In no field is this more evident than in the adjustment of the discoveries of science, in the field of medicine, to the actual care of the sick and the injured. When we face such pressing problems as the distressing illness of our relatives, friends, servants, neighbors or acquaintances, we are acutely conscious of the great disparities that exist at the present time in the distribution of proper medical care to the various elements in our population.

Through the combined efforts of men and women working in the laboratory, the hospital, the clinic and the home in all parts of the world, we are in possession of sufficient knowledge in both public and private health to revamp our whole civilization if it could be put into universal use.

Here in the United States we have a most interesting practical problem. Some forty-eight states with separate governments, different constitutions, different laws and different methods of thought are united in a nation working under a constitution which does not lend itself readily to a centralized plan of health administration. Here too we have a strongly individualistic and self-reliant people

[1] From article by Ray Lyman Wilbur, M.D. Secretary of the Interior and Chairman of the Committee on the Costs of Medical Care. *Survey*. 63:429-30. January 1, 1930.

which has just passed through a momentous economic revolution based on discovery and invention with constantly elevating standards of living.

The health service of the people is largely cared for by physicians and surgeons trained at different periods, under different conditions, and living in states with medical practice acts of great variety. In addition, there are a large number of individuals who are without adequate training but who deal with the sick either as practitioners or by assisting them in the purchase of a great variety of drugs and remedies. Hospitals and various institutions for the domiciliary care of the sick, the insane, the aged and the pensioned are scattered widely throughout the whole country. Some of these are controlled by the national government, some by the states, some by counties, some by municipalities, some by churches, some by voluntary organizations, and others by universities, corporations and persons. An immense amount of vested wealth is gathered about the hospital bed.

We have recently gone into the automobile era, with wide-flung highways. The American people have been put on wheels, so that distance no longer has its previous significance. Only a comparatively small percentage of our people have studied biology or have anything like an understanding approach to scientific medicine. For the most part, they are woefully ignorant of the real basis upon which modern medical science is acting. A large percentage of them are ignorant of all health laws, credulous to nth degree, and apt to view the art and science of medicine with a considerable degree of mysticism. Perhaps the most stable force in this whole problem is the organized medical profession. Yet the members of this profession are tradition-ridden and uneconomic in their thinking. They have grown up under the historical system of the charitable care of the indigent sick. They have been engrossed with their own busy lives in which they have had to concentrate all of their efforts on solving the personal, physical and mental affairs of others.

With the rapid changes going on in every phase of American life, the medical profession is constantly confronted with the fact that it is losing step, working at a disadvantage, and that unless order comes out of the present chaos in some way or in another, abnormal solutions may be developed in some of the forty-eight states which will be of great detriment to the interests of both patients and doctors.

THE ECONOMICS OF MEDICAL SERVICE[2]

In considering the economic factors of any problem, we are concerned with two fundamental conditions: (1) the cost of production, and (2) the purchasing power of the people.

The great majority of people have no direct concern with most of the misfortunes of life, with poverty, with penal institutions, with broken homes, but everyone, sooner or later, meets the problem of disease, the common misfortune of us all. Sickness and impairment constitute a problem so large as to touch every individual life, and so important in our political life as to be a matter of real concern to everyone who has risen to the level of citizenship.

The average individual between the cradle and the grave spends one-fortieth of his time in bed because of incapacitating illness. The average worker loses 2 per cent of his time, a fraction more than seven days a year, because of incapacitating illness.

One-fortieth of the population is constantly ill to the extent of being bedridden. Extensive and reliable studies indicate that where there is one person incapacitated, there are at least two physically impaired to the extent of from 10 to 50 per cent of their efficiency, which is to

[2] By W. S. Rankin, M.D., *Director, Hospital and Orphan Sections of The Duke Endowment, Charlotte, N. C.* From paper read at the Second General Session of the American Public Health Association at the Fifty-seventh Annual Meeting at Chicago, Ill., October 17, 1928. Reprinted from *American Journal of Public Health.* 19:359-65. April, 1929.

say that for every 1,000 people there are 50 who suffer from prevalent and chronic diseases that completely incapacitate for but a small part of their duration, such as tuberculosis, cancers, heart disease, vascular diseases, chronic indigestions, gallstones and kidney stones, hernias, unrepaired injuries following childbirth, etc.

The Cost of Medical Services

The annual expense to the people of the United States for medical services, if itemized and totalled, would read about as follows:

150,000 physicians, @ $3,000 per annum	$450,000,000
140,000 private duty nurses, @ $1,500 per annum	210,000,000
150,000 practical nurses, @ $1,000 per annum	150,000,000
100,000 attendants, @ $1,000 per annum	100,000,000
50,000 dentists, @ $3,000 per annum	150,000,000
7,000 hospitals, with a total of 860,000 beds	750,000,000
Druggists for medicines	700,000,000
25,000 healers, chiropractors, osteopaths, Christian Scientists, etc, @ $2,000 per annum	50,000,000
Grand Total	$2,560,000,000

The people of the United States, it will be noted, are paying for the treatment of disease not less than $2,500,000,000 a year, or ($2,500,000,000÷120,000,000 population) $20.83 per capita, or approximately $100 per family.

The average wage-earner's family, according to studies conducted by the U. S. Bureau of Labor Statistics, pays $60.39 a year for medical services. The average farmer's family, according to studies conducted by the U. S. Department of Agriculture, pays $61.60 a year for medical services. The average family represented in the clerical personnel employed by a large insurance company pays $80.00 a year for medical services.

Other and Larger Costs of Sickness

In addition to the expense for medical services imposed by disease, there is an estimated loss to the people

of the United States of $2,000,000,000, as a result of decreased wage-earning capacity. And this is not all—there is a still further loss of permanently interrupted wage-earning capacity through postponable deaths, estimated to be $6,000,000,000, making the total annual cost of disease to the people of this country $2,500,000,000 for medical services, plus $2,000,000,000 loss in wage-earning capacity, plus $6,000,000,000 death losses—a total of $10,000,000,000 a year. The total annual income of the United States is about $90,000,000,000.

The Purchasing Power for Medical Services

Any service which costs as much as medical care and which is so absolutely essential to both individual and national prosperity and happiness, raises at once the question of the ability of the people to pay for it. The income of the people of the United States, according to Leo Wolman, quoted in *The Survey* for June 15, 1927, was as follows:

6 per cent of families, annual income in excess of $2,900
90 per cent of families, annual income under $2,000
67 per cent of families, annual income under $1,450

There is a gap between the cost of medical service and the purchasing power of a large percentage of American families. The width of the gap may be measured to some extent by the percentages of people who are able (1) to pay in full, (2) to pay in part, and (3) to pay nothing for medical care.

According to the U. S. Bureau of the Census, in a study of "Hospitals and Dispensaries" in the United States as of the year 1923, 49.7 per cent of patients treated in general hospitals were able to pay in full; 19.3 per cent of patients paid in part, and 31 per cent of patients paid nothing.

Compared with these institutional payments for the care of the sick, we have no such reliable data as to the percentage of the people who (1) pay in full, (2) pay

in part, and (3) pay nothing for the services of physicians. It is reasonable to suppose that if we had such data, we would find the pecuniary relation of patient to physician very similar to that of patient to hospital. It is, therefore, reasonable to assume that approximately 50 per cent of the patients pay their physicians' bills in full, 20 per cent in part, and 30 per cent not at all.

Unquestionably, a large percentage of American people are not receiving the medical care that they should have, both as individuals and as units of society.

The gap between the cost of care and purchasing power is not due entirely to differences between the cost of service and the means for obtaining it. There is another factor in the situation too important not to deserve serious attention.

The expenses of being sick are unanticipated, appearing at unforeseen and irregular times, and are not like the expenses for food, clothing, shelter, etc., anticipated, appearing regularly and paid for in monthly accounts. If a family had its average annual cost for sickness of $60 to $100 a year apportioned and appearing at monthly intervals with the other family expenses, the problem would be met by a much larger percentage of people than can now meet it successfully. All too often the bill for sickness falls upon the victim in annual, biennial, or even quadrennial accumulations. When a family runs along for one, two, or three years, and then has a serious accident or illness, with a hospital bill, professional charges for surgeons and nurses—an account of $150 to $300—its economic stability is seriously jarred and often shattered. For a large percentage of families—that 50 per cent of American families whose annual income is below $1,200—when the unexpected and accumulated financial burden of sickness arrives, there is, as Dr. Michael M. Davis aptly says, one of these alternatives: medical charity or financial tragedy. It is, then, not the amount, so much as the condition of payment of the account with disease, that rips the family purse.

How can buckle and tongue be made to meet? What treatment will improve or relieve this social abnormality? What remedies may be considered.?

THE FINANCING OF MEDICAL CARE AS A PROBLEM IN FAMILY ECONOMY[3]

Illness imposes two sorts of financial burdens upon the average family: First, payment for the goods and services required to provide the patient with medical care, including nursing, medicaments, hospitalization, and the like; second, the loss of income that is entailed when a gainfully employed member of the family is ill. This paper is concerned only with the first of these two economic consequences of illness; the loss of income due to sickness is, generally speaking, capable of bringing about more spectacular economic collapse in the family than the former,[4] but it is not so widely significant. Illness almost always involves some form of expenditure, but it entails loss of income only when certain members of the family are affected, and not then unless it is disabling.

Moreover, virtually every family in society is, sooner or later, affected by some form of illness[5] involving financial outlay, unless it is so far below the poverty line as to be chronically and completely destitute, in which case it is not likely to preserve its integrity as a familial entity.

[3] From article by Niles Carpenter and others. *The Family.* 11:162-7. July, 1930.

[4] For instance "Family No. 22" in "The Fifty Neediest Families" as described in *The Buffalo Evening News,* December 14, 1929: "The father has been ill for many months. . . Illness has left the family destitute. . . When illness came . . . the meager resources of the family were dissipated. With no money coming into the house, the children soon began to feel the hardships that follow sickness in the homes of the poor. . . The family never had more than enough of the things that are called necessities, so that as soon as the wages of the father were cut off, want stared the family in the face."

[5] The healthiest of families must meet the expenditures of child-birth and of the fatal illnesses of each of its several members.

When the cost of medical care is envisaged as a family problem, six significant phenomena are noted: (1) Illness and, presumably, the necessity for medical expenditures, vary inversely as income: the poorer the family, the more sickness it suffers. (2) A substantial proportion of the illnesses affecting the American population do not receive professional medical care, largely, though not solely, because of the expense factor. (3) *Average* expenditures for medical care constitute a relatively small factor in family budgets, but (4) *individual* expenditures may be so great as to undermine the family's economic structure. (5) Some sort of sickness insurance is obviously indicated as a means for aiding the family to provide for sickness expenditures (as distinguished from indemnity for lost earnings), but (6) there is some question as to whether or not the existing income structure in this or any other industrialized country will make such insurance practicable for large sections of the population unless it is supplemented by the community, by industry, or by private donation.

Sickness and Economic Status

Selwyn D. Collins, of the United States Public Health Service, has recently published a summary of the literature, both foreign and American, dealing with the relationship between the family's burden of illness and its ranking on the socio-economic scale.[6] There is a general agreement among the studies that he quotes to the effect that low economic status and a high incidence of illness are correlated, both as regards sickness in general and specific illnesses.

Of particular interest to the student of family life in America are the results of two studies made by the United States Public Health Serice in twenty-four South Carolina cotton mill villages with a population of 22,000 during

[6] Collins. *Economic Status and Health* (Public Health Bulletin No. 165). Washington, 1927, *passim.*

1917,[7] and in the city of Hagerstown, Maryland, in 1921.[8] In South Carolina Sydenstricker and Wiehl found that "persons with relatively low incomes were affected in a much greater degree than the economically better off classes by severe illnesses in the late spring and early summer and by even more severe or chronic illnesses at all times." . . .

In 1921, Sydenstricker and his associates studied the disabling illnesses of 1,800 households in Hagerstown, Maryland, a city of about 30,000. Here also, poverty and sickness were found to be correlated. (See Table 2)

When these figures were adjusted for differences in the age composition of the three groups, the same relationships between them were maintained, although the contrasts were not so sharp.

Sickness Prevalence Among 7,524 White Persons Classified according to Family Economic Status, Hagerstown, Md., December, 1921 (*Sydenstricker*)

Economic Status	*Number of persons*	*Number of cases*	*Cases of sickness per* 1,000 *persons*
Well-to-do and comfortable	808	26	32.2
Moderate	3,400	128	37.6
Poor and very poor	3,316	133	40.1

It has been said that the inverse relationship between economic prosperity and the morbidity rate applies to virtually all individual causes of illness. Diabetes, gout, and cirrhosis of the liver, which are apparently related to nutritional unbalance and sedentary living, seem to show a contrary relationship, *i.e.,* the richer the family the more illnesses from these causes.[9]

Of particular interest to the student of family problems is the fact that both infant mortality and tubercu-

[7] Sydenstricker and Wiehl. "Disabling Sickness in Cotton Mill Communities of South Carolina in 1917." *Public Health Reports.* June 13, 1924.

[8] Sydenstricker. "Economic Status and the Incidence of Illness." *Public Health Reports,* July 26, 1929, quoted in *Monthly Review,* November, 1929.

[9] Collins. *op. cit.* p. 41; Sydenstricker. *op. cit.* p. 1084.

losis appear to be directly related to poverty.[10] In this connection, [consider the relation of] pulmonary tuberculosis among the Negroes in Chicago with the volume of physical production for the United States. It is seen that, after an initial period of adjustment to new environmental conditions, subsequent to their northward migration, the Negroes in this city have succumbed to tuberculosis in large numbers when production—and employment—was poor, and in small numbers when it was good. (A "lag" of about two years supervenes between the falling off in production and the rise in tuberculosis.) The white tuberculosis rate, on the other hand, shows no such trend, probably because the Negro, being largely engaged in unskilled industrial labor in the northern cities, is on a narrower economic margin than the average white person, and also feels the effect of industrial stoppage much more promptly.[11]

Failure to Utilize Professional Medical Care and Economic Status

There is a widespread assumption in this country that, in some way or another, every individual who needs medical care receives it. This assumption is very far from the fact. A surprisingly large proportion of illness in this country goes unattended by a physician. Sydenstricker's Hagerstown survey found that, during a period of something under three years (1921 to 1924) a total of only 7,953 out of 17,217 disabling illnesses of three days or more duration were attended by physicians; that is to say, only 46 per cent of these illnesses received medi-

[10] Collins, *op. cit.* p. 47-69. See also Woodbury. *Infant Mortality and its Causes, Baltimore,* 1926. Chapter VII. Newholme. *Vital Statistics* (Revised Edition), New York, 1924, p. 295-6.

[11] This fact probably accounts for the failure of Ogburn and Thomas to find any relationship between tuberculosis and the business cycle, *i.e.,* they took into account both Negro and white rates, and industrial and non-industrial populations. Moreover, their series (1870-1920) covered for the most part a period in which the Negro had not yet entered industry on a larger scale. See Ogburn and Thomas. "The Influence of the Business Cycle on Certain Social Conditions" in *Journal of the American Statistical Association.* (Vol. XVII N.S. No 139), September, 1922 (as cited in Collins. *op. cit.,* p. 67)

cal attention. When minor respiratory and digestive disturbances were eliminated, it still appeared that 35 per cent of the illnesses remained uncared for by a qualified medical practitioner.[12] When note is taken of the particular illnesses which are neglected in this way, it is seen that they are not all, by any means, minor ones. Influenza and grippe, for example, were attended by a physician in only 67 per cent of the illnesses; total deaths in the United States from these causes were, in 1925, 30,000.

The Hagerstown study contributes definite testimony, moreover, to the effect that economic status is one of the factors contributing to the neglect of competent medical care. "In general," says Sydenstricker, "those families which were definitely above the average of this community in economic condition had medical attention to a considerably greater extent than the remainder of the population"

More impressive yet is the evidence presented in a recently completed study made by the United States Bureau of Labor Statistics covering the budgets of 506 families of government employees in the cities of Baltimore, Boston, Chicago, New Orleans, New York, and St. Louis, for the year ending June 30, 1928. This investigation showed a clear cut inverse relation between the amount spent per capita for medical care of all sorts and income.

In a study of about 200 working-class families in the cities of Binghamton, Johnson-City, and Endicott, New York, made while I was on the staff of the Committee on the Cost of Medical Care, I found that those families which were receiving gratuitous medical care from the Endicott-Johnson Company called physicians more often and more promptly than those families, of the same general economic and social category, who were paying directly for their medical and hospital attendance. There

[12] Sydenstricker, "The Extent of Medical and Hospital Service in a Typical Small City," *Public Health Reports* (Vol. XLII, No. 2), January 14, 1927. p. 127.

was an even more marked difference between the two groups in the degree of use made of hospital facilities.[13]

Neglect of necessary medical care by the economically disadvantaged family is found among the professional classes. Professor Peixotto, in her study of budgets of faculty members at The University of California, states that dental care, in particular, is neglected by the lower income families, since "the amount spent on dentistry increases directly with the amount of the total expenditure."[14]

Low Average Expenditure for Medical Care—High Individual Incidence

When the observer undertakes to account for the failure of low-income family groups to secure adequate medical care, he is confronted by a paradoxical but highly significant situation. It is this: Medical expenditures constitute a relatively small item in the family economy, *on the average,* but *they are so unevenly distributed* as to mount up to very large amounts in individual instances. In an earlier discussion[15] the writer called attention to this fact, in particular with regard to a certain middle western hospital, where 982 patients paid an average of $59.37. There were, however, sixteen individuals whose bills amounted to $300 or over, and two who paid $1,000 or over. Indeed, over half (51.7 per cent) of all the money received by the hospital from this group was paid by slightly over one-sixth (17 per cent) of the group.

More recently there have appeared two budgetary studies which furnish additional evidence on this point. The first is the United States Bureau of Labor Statistics family budget investigation referred to above which indicates the low average expenditure for medical care.[16]

[13] The detailed data on which these statements are based are contained in *A Survey of the Endicott-Johnson Workers Medical Service*: Niles Carpenter. The Committee on the Cost of Medical Care, Washington, D. C.

[14] Peixotto. *Getting and Spending at the Professional Standard of Living.* New York. 1927. p. 205.

[15] Carpenter. "The Social Cost of Illness." *The American Labor Legislation Review* (Vol. XIX. No. 2). June, 1929. p. 160.

[16] *Monthly Labor Review* (Vol. XXIX, Nos. 2, 3, 4, 5). August-November, 1929.

The second, which covers Yale University faculty members, brings out both the low average and the high individual outlay for this purpose.[17]

[In the first] medical costs—and they include "doctor, medicine, hospital, nurse, dentist, oculist, glasses, etc."—came to about one-fourth of clothing, one-fourth to one-sixth of housing, and one-seventh to one-tenth of food. In two of the five cities, medical expenses average less than heat and light, and in one they run less than the cost of house furniture and furnishings.[18] Expenditures for medical and allied services are thus seen to constitute a significant proportion of the budgets of these families, but by no means a large one.

The Yale study, recently published by Henderson and Davie, is based on the year 1927. It does not give complete data on medical expenditures for all the families covered. Data are presented, however, for 48 families, and yield a mean average of $433 for the entire group. The upper quartile, however, had an average expenditure of $1,304, while the lower quartile had one of $48. The upper fourth, indeed, bore three-fourths of the entire burden of the medical expenditures of this group.[19] Nor is this all. These figures cover only those families which reported medical expenses. Those whose medical costs were nil or were too small to be singled out from the total of medical expenses are not included. If they were, an even greater degree of inequality of incidence in medi-

[17] Henderson and Davie. *Incomes and Living Costs of a University Facility*. New Haven. 1928.

[18] As a matter of general interest, average medical costs were compared with certain so-called luxury expenditures, since it is sometimes claimed that the average American family will neglect necessary medical expenditures for the sake of recreation and non-essentials. So far as the group included in this study is representative, this assertion does not seem to be based on fact. Medical expenditures equalled about 5 per cent of the total outlay of the entire 506 families; automobiles (purchase and upkeep), 2.4 per cent laundry, 1.5 per cent; amusements, 1.5 per cent, and radio, 0.7 per cent. On the other hand, it is possible that the clothing expenditure noted above contains some luxury spending.

[19] The actual quartile distribution is: Q_1—$48.21, or 2.4 per cent of total; Q_2—$126.21, or 7.3 per cent of total; Q_3—$259.50, or 15 per cent of total; Q_4—$1,304.16, or 75.3 per cent of total.

cal costs would be revealed. For example, in one group of seven families, such costs average $17.50, but two families paid more than twice this average ($40) and two paid nothing at all! The distribution as it is given for the 48 families, therefore, seriously understates the degree of the inequality of the incidence of medical expenditures in this faculty group.

Professor Peixotto's study of University of California faculty families gives similar results. Medical costs for the group average 4 per cent of all expenditures, or about $200. But "one instructor's family of four people, living on $2,400, spent $600, 25 per cent of their total expenditure—for health. Two-thirds spent less than $250; 25 per cent less than $100, but 16 per cent spent more than $500. Five families, two of which had incomes under $5,000, spent between $1,000 and $2,000."[20]

It is true that these studies are based on small samples, but they represent widely scattered sections of the United States, and cut across the various sections of the middleclass economic group; so that they are probably fairly representative. It is to be hoped that the Committee on the Cost of Medical Care studies,[21] which cover several thousand families, will furnish definite data on this subject.

THE COST OF MEDICAL CARE[22]

How much does the workingman's family spend for sickness during the year? How much for the care of the teeth? For the care of eyes? How much goes to the doctor? How much for medicines, nurses, hospital

[20] Peixotto. *op. cit.* p. 204.

[21] *The First Two Years' Work of the Committee on the Cost of Medical Care,* Washington. 1929. p. 13. The studies are numbers 6 and 6a in the Committee's "Program of Studies."

[22] From *The Cost of Medical Care,* by Lee K. Frankel, 2d Vice-President, Metropolitan Life Insurance Co. 11p. pa. Published by the Committee on the Cost of Medical Care. Wash. D. C. 1930.

care, operations? There are very important questions which must be answered before any forward steps can be taken toward improving health service in the United States. The Metropolitan Life Insurance Company has attempted to obtain answers to these important questions by the most direct method available, namely, by sending its trained and experienced visiting nurses into the homes of its Industrial policyholders and asking for the information.

It should be mentioned here that the Company extends a visiting nurse service to its Industrial policyholders. In communities in which there is a visiting nurse association the Company arranges with the association to give such service. In other communities, the service is rendered by nurses in the employ of the Company. While these nurses are located in thirty-five states, as a rule they are not employed in the larger cities in which there are nursing associations, but in smaller cities and towns. Some of the schedules, however, were received from the cities of Boston, Baltimore, and Chicago in which the Company has recently installed advisory nurses, whose services were used in this survey. It is our belief, however, that the data obtained fairly well reflect conditions throughout the United States.

How the Data Were Obtained

These nurses, during January of 1929, called upon families located in the industrial centers of practically every state of the Union and distributed schedules in the form of calendars on which the policyholders were requested to keep a careful record, day by day, for six months, to show what their families paid out for doctors, nurses, medicines, for care of teeth, for care of eyes, and for all other items for which expenses might be incurred on account of sickness or injuries. . . The schedule form was made extremely simple and each family was instructed by the nurses as to the manner in which the

various columns should be filled in. Furthermore, the families were revisited each month in order that their interest in the survey be sustained and to assist them in keeping the records accurately. At the close of the sixth month, in July, 1929, the nurses collected all the calendars and returned them to the Company. It was very gratifying to find that the schedules were very satisfactorily completed and gave every indication of having been done accurately and with considerable care. We feel confident that the results of this survey are representative of the costs of medical care during the first six months of 1929, to families located in the industrial centers of the United States.

Summary

1. Practically every family had to make some expenditure for medical services during this period. Among 3,281 families, consisting of 17,129 persons, only 198 families reported no expenditure.

2. The total amount disbursed by all families was $230,907, an average expense of $70 per family for six months or $140 estimated for a complete year.

3. A large share of this outlay fell upon a small proportion of the families; 64 per cent of the total amount was expended by one-fifth of the total number of families.

4. Private physicians received the largest share, 43 per cent of the total amount expended. But if expenditures for the care of teeth, care of eyes, and extra household disbusements are excluded, this ratio for physicians amounts to 54 per cent. One-fourth of all the money paid out went for medicines and hospitals, about an equal share for each.

5. Eighty-two per cent of the families used the services of a private physician and 83 per cent needed medicines during this period. Thirty per cent of the families reported expenses for care of teeth and 9 per cent for care of eyes. Hospitals were used by 15 per cent of the families. More than one-third of the families re-

ported extra household expenses as a result of sickness or injuries.

6. Families that had the services of a private physician paid him an average of $37 over a period of six months. Those that required hospital care paid an average of $60 for this service, and those that had operations paid an average of $74 for this special service.

7. Members of large families cannot afford to pay as much for medical care as can those in smaller families. Persons living alone paid out an average of $75.63 in six months for medical care, whereas those in families of nine or more persons paid out only $6.64 during the same months.

Conclusions

The question may well be asked whether the figures presented are truly representative of conditions in the United States. Any one who has ever attempted to keep a daily budget of expenses knows very well how difficult it is to remember all of the items. It is quite likely, therefore, that the data obtained by the nurses are not altogether complete, and it is our impression that the figures of cost are minimal for this group of people. If every item of cost had been included, the figures would have been somewhat higher. But one element is especially disconcerting and that relates to the value of the medical care received from clinics and from other agencies, either without any cost or at the usual small charges which are made. That working class families avail themselves of this type of medical service, which should be added to our total figures must remain problematic. Nevertheless, the figure of $140 per annum does present a fairly inclusive picture which will serve very useful purposes in the discussion of medical costs under present conditions.

The marked differences in the expenditures per capita between large and small families is also worthy of notation. Where there are only two in the family, the average expenditure per person is $41.24, with eight members

in the family, the average per capita expenditure was only $10.44 during the same six months' period. The larger the family, obviously the less money is available for individual members to obtain adequate medical care. It would seem reasonable to suppose that where families are large, economic conditions make it almost inevitable to throw such families on clinics and other public agencies where medical care is obtained free or much below actual cost. It is, of course, also possible that in such families of large size, resort is made to home remedies and home care where conditions call for hospital and other medical service.

The data indicate clearly one fundamental fact, namely, that sickness is a hazard of life comparable to other hazards, such as death and accident. The latter have been provided for in our scheme of things through insurance. Loss of wages due to illness has also been provided for in many countries through insurance schemes. The cost of medical care must likewise be furnished through some such method. With the knowledge obtained as to the cost of sickness in this and in other studies now being conducted by the Committee on the Cost of Medical Care, it is hoped that a definite basis for the actuarial calculation necessary to introduce insurance methods will be arrived at. These financial calculations are in themselves comparatively simple. The real problem will be to provide systematized medical service which shall be adequate in the broadest sense. This is, in the last analysis, a problem for the medical profession and one which must be given early consideration.

CHILD HEALTH VERSUS THE POCKETBOOK[23]

How much does child health cost, how shall it be paid for, and who shall pay for it? Health departments and

[23] Taken from an article on "Child Health versus the Pocketbook" by Michael M. Davis. *National Conference of Social Work. Proceedings.* 1928: 213-14.

voluntary health agencies have established certain standards or requirements in their child health programs. These standards include care for the mother and care at delivery by a physician skilled in obstetrics, and during the baby's first year, periodical examination and advice to the mother by a physician especially trained in the disease of children, aided by a public health nurse. In the preschool and school years it is accepted as desirable that children receive systematic medical supervision by qualified physicians and follow up by nurses. Immunization at as early an age as possible against certain diseases, especially smallpox and diphtheria, is part of the child health standard, and also systematic examination, cleansing, and necessary care of the teeth during the preschool and school period. These health services are provided by the community for a certain number of children, and for some additional children by their own parents.

Opinion as to the proportion of children for whom health service should be furnished by public or private agencies varies among health workers and among practicing physicians. We find those who appear to assume that child health programs might well be extended by the community to all children; and there are those on the other hand who would limit them strictly to the children of the truly poor. The abstract question of public policy is a matter of argument. The concrete questions of the expense of child health work is a matter of fact. Suppose we were to take standards and methods of child health service which have become fairly accepted parts of public health practice and inquire as to their applicability to private health practice—that is, ask how much the services according to such standards would cost if secured by each family for its own children.

I have estimated these costs as follows: The expense of prenatal and obstetrical care, including professional fees, hospital care, or home service, baby clothes, and incidentals has been taken as $150. I do not imply that good care is not secured in some communities for less

than this; I do estimate that the standards of good care generally set by health agencies for their clients would usually call for at least this expense.

EXPENSE OF HEALTH SERVICE TO A CHILD FROM BIRTH THROUGH THE FOURTEENTH YEAR

Kind of Service	*Items in Service*	*Expense of Service at Minimum Rate* ($)	*Expense for Whole Period of 14 years* ($)	*Average per Year* ($)
Prenatal and obstetrical ..	Prenatal examination and supervision; confinement and *post partum* care.	150	150	10.71
Pediatric	Systematic periodical supervision by pediatrician, with necessary tests and immunizations.	(1st yr..35) (2-5 " ..15) (6-14 " ..10)	185	13.21 17.50 4.29
Dental	Two prophylactic cleanings a year from 5th to 14th years.	6	60	
Total			395	28.21

OBSTETRIC COSTS[24]

An investigation was undertaken in Berkeley, Calif., regarding the physical conditions surrounding maternity and infancy. The sample used was based on the selection of every third birth registered in the city during 1928. A total of 390 obstetric cases was the basis of the investigation and data on cost of obstetric service were obtained for 376 of these cases.

In the series of 390 cases, 144 individual physicians were in attendance, giving an average number of 2.7 confinements per physician. One of the outstanding facts of this study was the large number of Berkeley mothers confined in hospitals. Of the 390 deliveries, 85.6 per cent occurred in hospitals. During 1928, 83.51 per cent of the

[24] From "The Cost of Obstetric Service to Berkeley Mothers," by R. A. Bolt. *American Journal of Public Health.* 20:882. August, 1930.

total live births occurred in hospitals and 28.9 per cent of these in one hospital. The average number of days spent during confinement in hospitals was 10.

In taking physicians' charges, the amount billed to the patient was used. The average cost per obstetric case was $92.12, with a median of $73.87. The modal or most frequent charge was $50. There was no charge by the physician to 6 patients; the other expenses in these cases totaled $760.75 or $126.79 per case. Thirty-one deliveries took place in the hospital; 17 of the 31 patients paid $249.80, averaging $14.69 per case; the other 14 paid nothing for their obstetric care. The sums paid ranged from $.50 to $70. Six of the 390 confinements were among industrial policyholders of the Metropolitan Life Insurance Company. The total cost of their obstetric service was $338.65, averaging $56.44 per confinement. Only one was confined in a hospital at a total cost of $103.65. The physicians' charges in these cases were $50 apiece for 4 and $35 and $25 for the other 2.

The total cost of obstetric service to Berkeley mothers, in which at least one item of cost is represented, averaged $213.75 per case. In half of the cases the charges were $179.41 or less. The average calculated on the basis of the 390 cases, including patients who did not pay anything, would be reduced to $206.07. It is safe to state that the total cost of the average obstetric case in Berkeley is somewhere between $200 and $215. In exceptional cases and especially those with complications, it may run to $1,000 or even to $1,800. The mean cost per case for nursing service was $116.21 with a median of $89.

MEDICAL FACILITIES IN THE UNITED STATES[25]

Each year disease and defectiveness levy a large toll of suffering, inefficiency and death upon the people of the

[25] By Allon Peebles. Abstract. 17p. pa. Published by Committee on Cost of Medical Care. Wash. D.C. 1929.

United States. What are the facilities now available for dealing with these conditions?

This outline presents certain basic statistical data concerning existing medical facilities. The subject matter is largely statistical, but the reader is urged to remember that figures, like men and women, differ in the quality of their ancestors or origins and in their reliability. Such statistics have a value and importance, although other facts not statistically measurable must also be given due weight in estimating the availability and value of medical facilities.

I. Practitioners and Other Individuals

Perhaps the outstanding fact regarding medical facilities[26] in the United States is that there are approximately 1,500,000 persons estimated to be employed in connection with the care and prevention of illness. This army is greater than the population of a city as large as Detroit! The accompanying table shows how this total is divided among the various types of professional groups and services. Some items in the table are the result of careful enumerations, others are estimates.

	Enumerations	Estimates
Physicians	143,000	.....
Attendants of physicians	.....	24,000
Dentists	67,334	.....
Dental hygienists	.....	1,800
Dentists' assistants	.....	12,000
Dental technicians	.....	10,000
Physiotherapists	500	.....
Osteopaths	7,602	.....
Naturopaths	.....	500
Electrotherapists	.....	300
Chiropractors	.....	15,000
Christian Science practitioners	8,500	.....
Trained nurses	.....	200,000

[26] The word "medicine" is used in this study (according to the definition of Webster) as "the science and art dealing with the prevention and cure or alleviation of disease." It therefore includes the private practice of physicians, dentists, nurses and other individuals, and the work of all types of medical and public health agencies. Likewise, "medical facilities" and similar terms have the same comprehensive meaning.

	Enumerations	Estimates
Practical nurses	151,996	.....
Midwives	.....	55,000
Hospital superintendents (not included above)	2,600	.....
Hospital personnel (not included above)	.....	550,000
Clinic attendants (no included above)	.....	5,000
Optometrists and opticians	18,079	.....
Chiropodists and podiatrists	.....	7,000
Masseurs	.....	3,000
Pharmacists	.....	100,000
Drug clerks and assistant registered pharmacists	.....	84,000
Health department personnel (not included above)	.....	11,500
Clinical laboratory personnel	.....	1,400
Personnel of private health organizations (not included above)	.....	1,000
Totals	399,611	1,081,500
Grand total		1,481,111

How rapidly have medical practitioners been increasing in the United States? Physicians have not been increasing as rapidly as population. Dentists have increased at a greater rate than population, while registered nurses have grown even faster, Hospital beds and clinics,[27] discussed later in this report, also show rapid rates of increase, clinics having the most spectacular growth of all.

Physicians

There are in the United States more physicians per 100,000 people than in any other country in the world. While the number of doctors has not been increasing as rapidly as has the population, it does not follow necessarily that there is, or will be, an inadequate supply. Improved transportation, the growth of office practice and many other changes may have more than counterbalanced the decreased ratio of physicians to population.

[27] The terms, "clinics," "dispensary" and "out-patient department," are often used interchangeably. In this publication the term "clinic" is used as "an institution receiving ambulatory patients for diagnosis, therapuetic or preventive medical service."

The sufficiency of physicians in the United states is affected not only by their number in the country as a whole, but by their geographical distribution. This is decidedly uneven. In 1927 South Carolina and Montana had only 71 physicians per 100,000 people; California, at the other extreme, had 200. Various state surveys show clearly that the larger cities are over-supplied with doctors relative to population, whereas smaller towns and rural districts are *relatively* under-supplied. Comparatively few recent graduates of medical schools are located in the small communities; the proportion settling in the larger cities is becoming progressively greater.

This is an age of specialization. Over 19,000 doctors in the United States limit their practice to a special field of medicine. There are 20,000 others practicing a specialty but not limiting themselves to it. The tendency towards complete specialization is particularly marked in cities larger than 25,000.

The number of physicians employed full-time on a salary basis, including those in governmental service, is, according to one estimate, at least 11 per cent of all active doctors in the country.

Dentists

In recent years the importance of dentistry and oral hygiene to general health has been more widely recognized. Dentists have increased rapidly since 1900, there being over 67,000 in the United States at present. They are unevenly distributed over the country—some urban centers have one dentist to every 500 people, while some rural communities have only one dentist to every 4,000 people. Likewise the supply varies considerably from state to state; the extremes for 1928 were California with 103 dentists and Mississippi with 19 dentists per 100,000 population.

There has been considerable division of labor in the field of dentistry. This has taken the form of specialization among the dentists themselves and the development

of such occupational groups as dental hygienists and dental technicians.

Nurses

There are approximately 200,000 graduate registered nurses in the country at the present time. About 152,000 practical nurses were reported in 1920 by the census. In regard to the supply of registered nurses, the Committee on the Grading of Nursing Schools states, "While many positions for nurses remain unfilled, there is no lack of applicants. The shortage is not in quantity, but in quality." As with doctors and dentists, there is considerable variation in the distribution of graduate nurses. The number ranged in 1920 from 39 per 100,000 people in Mississippi and Arkansas to 297 per 100,000 in California. Moreover, trained nurses, like other professional groups, are concentrated in the larger cities while rural sections are comparatively under-supplied.

Some Other Groups

There are several additional professional and semi-professional groups engaged in ministering to the sick, varying considerably in function and training. The numbers of pharmacists, drug clerks, optometrists and opticians, physiotherapists and chiropodists in the United States are found in the table on pages 70-1.

When one is ill, what are the various choices open for professional service? In the nation there are 143,000 doctors of medicine and about 32,000 other practitioners who take charge of cases. These include chiropractors, osteopaths, naturopaths and Christian Scientists. The number of these other practitioners are found in the table on pages 70-1. At least 55,000 women, chiefly in the southeastern states, practice midwifery, many of them, however, on a part-time basis.

II. Institutions

The professional services sought by the sick may be rendered in the home of the patient, in the office of the

practitioner or under the auspices of organizations or institutions. Included among the last are hospitals, clinics, health centers, drug stores and clinical laboratories.

Hospitals

Hospital beds have increased from 421,000 in 1909 to 890,000 in 1928. There are 7,000 hospitals in the United States in 1927:

Nervous and mental	373,564
General	345,364[28]
Tuberculosis	63,170
Isolation	8,895
Convalescent and rest	8,143
Industrial	7,039
Maternity	5,747
Orthopedic	5,595
Children's	5,050
Eye, ear, nose and throat	2,832
Skin and cancer	949
All other hospitals	5,240
Hospital departments of institutions (prisons, orphanages, etc.)	21,930
Total	853,318[29]

Hospital facilities appear to be unevenly distributed. Over 40 per cent of the counties in the United States have no hospitals for general community use.[30] All of these counties may not need hospitals, however, on account of sparseness of population, adequate facilities in nearby counties or other considerations. The individual

[28] General hospitals, of course, have beds for some or all of the other types of service enumerated in the table. The total number of beds devoted to a particular kind of service is, therefore, larger than the total bed capacity of those hospitals devoted exclusively to that service.

[29] 41,961 bassinets for new-born babies not included. In 1928 the total number of beds and bassinets was about 935,000.

[30] These include only hospitals available to all the sick and injured of the local community. They do not include hospitals whose use is restricted to veterans, members of the merchant marine and employees of the federal government, or to members of certain fraternities or other special groups; nor do they include state tuberculosis and mental hospitals and similar institutions.

states show a range from 1 bed per 154 persons in Wisconsin to 1 bed per 749 persons in South Carolina. Smaller cities have, in proportion to population, fewer hospital facilities than larger cities.

Of the entire bed capacity of the country, considerably over one-half is provided by the federal, state and local governments; over one-quarter is provided by non-profit organizations for public service, controlled by independent boards of trustees, churches and other bodies. The remaining small proportion of beds are in proprietary hospitals, mostly of small size, set up as business enterprises under the ownership of individuals or corporations.

By 1927 clinical laboratories had been established by about 4,400 hospitals; X-ray departments were reported by about the same number; physical therapy departments by 2,100.

Clinics, Health Centers and Other Institutions

The rapid growth of clinics from about 600 in 1910 to almost 6,000 in 1926 is indicated. . . These clinics are maintained by hospitals, governmental and private health organizations, industrial and commercial establishments, schools and colleges, trade unions, courts and prisons, and charitable agencies. Over 2,100 hospitals in 1927 had out-patient departments for the care of ambulatory patients—a function of increasing importance. Among recent developments are "pay clinics" (still very few in number) and "group clinics." In these clinics are gathered together a man with experience in general diagnosis and one or more specialists, with more or less complete equipment for providing scientific medical service, all under single administrative control. While "group clinics" are not usually organized for the purpose of reducing fees, "pay clinics" charge fees approximately covering the cost of service, including remuneration for the physicians.

The following table, incomplete in minor respects, gives the number of clinics in June, 1926:

Out-patient departments		1,790
Of medical schools	50	
Of general hospitals (excluding federal and industrial)	1,252	
Of special hospitals		
Nervous and mental	197	
Tuberculosis	107	
Children's	52	
Women's	49	
Eye, ear, nose and throat	37	
Orthopedic	26	
Other	20	
Unattached clinics		2,793
General	347	
Tuberculosis	585	
Venereal disease	350	

Somewhat different from the clinic is the health center, several hundred of which have been established in recent years, especially since the war. The "health center" usually brings together under a single roof a large number of previously scattered activities for the prevention of disease and the promotion of health. It provides, promotes and coordinates medical service and educational work.

About 57,000 retail drug stores in 1927 were serving the United States. In addition to the clinical laboratories in hospitals, there are almost 1,000 private clinical laboratories.

III. Governmental Agencies and Private Health Organizations

The promotion of community health is an important governmental function; there is also a legitimate field for the private agency in the promotion of the public health.

Governmental Agencies

With the general increase in its activities and powers, the modern state has assumed a more and more important role in maintaining public health. It is note-

worthy that, among their other functions, federal, state and local governments controlled hospitals which in 1927 rendered 70 per cent of all hospital service in the United States. These, of course, include large institutions for mental, tuberculosis and other special groups of patients, as well as some general hospitals.

There are about 25 agencies in the federal government doing some kind of medical work. The Public Health Service renders important services in the prevention and control of epidemics, conducts research and operates 25 hospital and 126 out-patient stations for merchant seamen and other beneficiaries. The Children's Bureau collects and disseminates information regarding infant mortality and diseases of children. It has established maternal and infant health centers in cooperation with the states. Among other agencies providing personal medical service is the Veterans' Bureau.

State departments of health engage in the control of communicable diseases, the collection of vital statistics, the control of the water supply and the disposal of sewage, the inspection of food, the maintenance of diagnostic laboratories, and the dissemination of information regarding health and the prevention of disease. The states also maintain hospitals for nervous and mental patients, tuberculosis sanatoria, and institutions for the blind, deaf and mute, feeble-minded and epileptic.

The city or county health department is the primary unit for administering official public health services. Health officers were employed on a whole-time basis, in 1928, by 354 of the 824 cities in the United States with over 10,000 population. Of about 2,500 counties, wholly or in large part rural, 414 at the beginning of 1928 had health departments with one or more health officers on a whole-time basis.

Private Health Organizations

The growing popular interest in public health activities has been stimulated by the establishment of twenty

or more voluntary health agencies of national scope and importance and a large number of such local agencies. Some of the fields covered by these associations are tuberculosis, child health, heart disease, social hygiene, mental hygiene, cancer and blindness. In addition to the educational work performed by all of these organizations, some provide certain kinds of medical service.

MEDICAL EDUCATION IN THE UNITED STATES[31]

The statistics herewith presented for the year ending June 30, 1925, are based on reports received from the medical colleges and other reliable sources. We acknowledge here the kind courtesy and cooperation of the officers of the colleges who have made the compilation of these statistics possible.

Number of Medical Students

The total number of medical students in the United States for the year ending June 30, 1925, excluding premedical, special and postgraduate students, was 18,200, an increase of 472 over last year. This is the largest enrolment of students since 1912. Enrolments in certain previous years are given for comparison. There has been a steady increase in enrolment since 1919. Of the total number of students last year, 17,652 were in the nonsectarian (regular) colleges, 410 at the two remaining homeopathetic colleges and 148 at the one remaining electic college. The three nondescript colleges reported neither students nor graduates for the session ending in 1925.

Number of Medical Graduates

The total number of graduates for the year ending June 30, 1925, was 3,974, or 412 more than last year.

[31] Taken from article "Annual Presentation of Educational Data for 1925" by the Council on Medical Education and Hospitals. *Journal of the American Medical Association.* 85:90-4. August 22, 1925.

This is the largest number graduating since 1913. The number of graduates from the non-sectarian colleges was 3,856, or 461 more than last year. The number from the homeopathic colleges was 80, or 6 more than last year, and from the ecletic college there were 38, or 11 more than last year.

Number of Colleges

The numbers of medical colleges existing in certain years since 1850 are shown in Table 7. Since 1920 this number has gradually decreased from 85 until last year when the lowest number, 79 was reached. This year, however, the new medical school of the University of Rochester, N.Y., is open to receive medical students. This brings the number back to 80.

TABLE 7

1850	44	3	4	1		52
1860	53	6	4	2		65
1870	60	8	5	2		75
1880	76	14	8	2		100
1890	106	16	0	2		133
1900	126	22	9	2	1	160
1906	130	19	8	3	2	162
1910	109	12	8	1	1	131
1915	83	9	4			96
1920	76	5	1		3	85
1921	74	5	1		3	83
1922	74	3	1		3	81
1923	74	2	1		3	80
1924	73	2	1		3	79
1925	74	2	1		3	80

College Fees During Fifteen Years

Tuition fees in medical schools have been gradually increased during the last fifteen years. From 1910 to 1914, the majority of medical schools were charging fees of $150 or less. From 1914 to 1922 the majority were charging fees of $200 or less, while since 1922 the majority includes several medical schools charging more than $200. The number of medical schools charging more than $200 increased from 2.3 in 1910 to 56.2 in

1925. The average fees charged per student by all colleges in 1910 was $118; in 1915 it had increased to $145; in 1920 to $177 and 1925 to $236. The fees in the present year, on the average, therefore, are just twice as large as in 1910. In 1910 there were still several medical schools which were paying all expenses or making a slight profit from students' fees. At present, however, the colleges are expending in the instruction of each student from two to several times as much as he pays in fees. This is made possible because of state aid or private endowment. No medical college in this period of scientific progress can maintain the laboratories and pay the essential instructors and properly teach modern medicine on the income received alone from students' fees.

As the cost of conducting medical schools has increased, there has also been an increase—and properly so—in the fees charged for tuition. A large provision has been made for scholarships and loan funds for the benefit of deserving students who are financially poor. Nevertheless, there is need for more such scholarships. Scholarships and loan funds are particularly important now because the medical curriculum has become so severe that students cannot spare the time to earn money during their attendance at the medical school. A mere lack of funds should not be permitted to prevent any exceptionally qualified student from becoming a physician.

Proportion of Physicians to Population

A study of Table 14 is interesting in that it shows the states which are best supplied with physicians. The states which have the lowest proportions of physicians in their order are North Dakota with one physician to every 1,386 people; South Carolina, one to 1,325; North Carolina, one to 1,178; Montana, one to 1,164; Idaho, one to 1,130; South Dakota, one to 1,085; Alabama, one to 1,061; Mississippi, one to 1,052, and Arizona, one to 1,008. In the United States as a whole there is now one

physician to every 753 people as compared with one to 724 in 1923; one to 720 in 1919, and one to 640 in 1913. In 1921 statistics showed that, next to the United States, Great Britain had the largest supply of physicians, or one to every 1,087. In 1910, in Mr. Flexner's report, Great Britain is accredited with one physician to every 1,500 people, while in central European countries the proportion was from one to 2,000 to one to 2,500 people. In the United States the fact that numbers of graduates are again rapidly on the increase indicates that there will be no serious shortage in the supply of physicians.

Table 14. *Proportion of Physicians to Population*

State	Population, 1923 Estimate	Total No. Physicians, 1925	People to each Physician, 1925
Alabama	2,423,912	2,284	1,061
Arizona	380,960	379	1,008
Arkansas	1,816,287	2,212	821
California	3,805,153	8,363	455
Colorado	990,320	1,837	539
Connecticut	1,476,483	1,884	784
Delaware	230,460	256	900
District of Columbia	*437,571	1,813	242
Florida	1,046,287	1,452	721
Georgia	2,999,196	3,122	961
Idaho	470,179	416	1,130
Illinois	6,790,524	10,743	632
Indiana	3,013,134	4,251	709
Iowa	2,468,643	3,378	731
Kansas	1,797,489	2,364	760
Kentucky	2,462,317	3,041	810
Louisiana	1,849,746	1,991	929
Maine	777,259	1,037	750
Maryland	1,505,295	2,313	651
Massachusetts	4,027,545	6,187	651
Michigan	3,977,821	4,837	822
Minnesota	2,499,396	2,823	885
Mississippi	[82]1,790,618	1,702	1,052
Missouri	3,443,971	5,806	593
Montana	611,199	525	1,164
Nebraska	1,333,922	1,869	714
Nevada	*77,407	129	600
New Hampshire	477,592	601	745

[82] Population, Jan. 1, 1920; no estimate made.

State	Population, 1923 Estimate	Total No. Physicians, 1925	People to each Physician, 1925
New Jersey	3,378,963	3,567	947
New Mexico	372,265	365	1,020
New York	10,813,661	17,671	614
North Carolina	2,686,325	2,281	1,178
North Dakota	672,041	485	1,386
Ohio	6,177,122	8,113	761
Oklahoma	2,162,079	2,524	857
Oregon	823,270	1,176	700
Pennsylvania	9,100,326	11,140	817
Rhode Island	626,672	771	813
South Carolina	1,744,408	1,317	1,325
South Dakota	655,532	604	1,085
Tennessee	2,393,077	3,128	768
Texas	4,939,630	6,063	815
Utah	476,812	505	944
Vermont	[32]352,428	537	656
Virginia	2,398,441	2,534	917
Washington	1,433,998	1,781	806
West Virginia	1,551,156	1,753	885
Wisconsin	2,739,574	2,826	969
Wyoming	211,864	255	831
Total	110,663,502	147,010	753

MEDICAL SERVICE IN INDUSTRY MAKING GREAT STRIDES [33]

In making a survey of the extent and character of the provisions made by employers for medical attention to the health of their employes, the National Industrial Conference Board found that in the approximately five hundred industrial establishments investigated the total annual expenditure for medical supervision exceeded five million dollars. In view of the fact that industrial medical service has in most cases been established within the last ten or fifteen years, the extent to which it has already been developed is most encouraging. It gives assurance that industry may be counted upon for substantial support

[33] From article by M. W. Alexander, President, National Industrial Conference Board. *Hospital Management.* 21:58-9. May 15, 1926.

in the campaign of society against sickness and accidental injury.

It is recognized that the enactment of workmen's compensation laws has been an important factor in bringing about the introduction of medical care of industrial workers. These laws, by placing upon the employer the responsibility for safeguarding his employes against accident, direct attention to the fact that by careful supervision of the health of the worker, the safety of processes and of materials used are the surest means for prevention of injuries and illness of the workers. Moreover, the initial experiments in this field demonstrated that fatigue reduced productive energy and that sickness and physical unfitness affected the ability of a workman to deliver a maximum output with the minimum of endeavor. Employers found that the conservation of labor energy was not only socially desirable; but that it was profitable. Finally, the development of industrial medical service was stimulated by the human interest of industrialists in the well-being of their co-workers in their enterprises. Not content with the prevention of accidents and occupational disease, many industrial establishments today are furnishing their employes with a complete remedial and diagnostic service. This extension of the activities of medical departments represents something more than a profit-making interest on the part of employers in the men and women whom they employ.

Average Cost $5.14

The cost of medical service in industry varies, as might be expected, with the type of service rendered and with the industry in which employed. In a survey covering 207 establishments made by the National Industrial Conference Board in 1920 it was found that the average annual cost per employe was $4.43. A recent investigation by the board, covering 447 establishments and 1,031,279 workers, showed this cost to be $5.14. This increase is probably due in large part to the increase in

the scope and functions of medical departments. In both investigations the highest average cost was found in the mining industry, in which, however, the outlay per workers was reduced from $24.40 in 1920 to $13.87 in 1924. In general, the chief item of expense, that covering the salaries of physicians and nurses, constitutes about 70 per cent of the total expenditures for medical service. The cost of medical supplies amounted to more than half a million dollars annually, averaging approximately $1,200 per establishment.

RESULTS OF A SURVEY OF 500 PLANTS

Size of plant	No. of Plants Reporting	Physicians			Nurses	Dentists	
		Full time	Part time	On call	Full time	Full time	Part time
Less than 500 employees ...	99	7	26	145	48	1	7
500 to 1,000 employes ...	125	12	65	168	113	..	5
1,000 to 2,000 employes ...	136	47	93	167	187	3	13
2,000 to 5,000 employes ...	96	105	76	189	194	5	11
5,000 to 10,000 employes .	29	44	35	44	95	2	26
10,000 and over	14	50	60	56	205	2	16
Total	499	265	355	769	842	13	78

BRIEF EXCERPTS

Public health is the foundation upon which rests the happiness of the people and the power of the state.—*Disraeli.*

To describe briefly the present system of medicine. . . is a difficult task. The conclusion may be reached that what exists is not so much a system as a lack of system.—*Harry H. Moore, in "American Medicine and the People's Health." p.* 21.

The enforced application of the knowledge now in the possession of the medical profession in regard to the prevention and cure of disease would be the means of saving upward of one-half million lives a year in the

United States alone.—*Robert E. Farr in the American Medical Association Bulletin. O. '23. p.* 398.

The one great outstanding problem before the medical profession today is that involved in the delivery of adequate scientific medical service to all the people, rich and poor, at a cost which can be reasonably met by them in their respective stations in life.—*Olin West, before the Annual Meeting for* 1924 *of the American Medical Association.*

We cannot consequently be satisfied with anything except the best possible medical service for the nation; it is not a matter of luxury or comfort, it is not a sacrifice to which we make consent on account of our human feelings; it is a wise investment we make which brings, in terms of prosperity and strength for the nation as well as of happiness for the family and the individual, a very high reward indeed.—*René Sand, former Secretary-General of the League of Red Cross Societies.*

It is estimated by the most careful and reliable authorities that about 2 per cent of the population of the United States are ill all the time—ill enough to be unable to attend to their daily tasks. This means that every day there are over 2,300,000 people sick in the United States. In New York City 15 per cent of the sick go to hospitals. In other communities this proportion is sometimes larger, sometimes smaller.—*Anne Miller Downes in "The Cost of Illness." Atlantic Monthly. O. '27. p.* 460.

Social conditions being what they are, the health of the individual is now of greater general importance than ever before. The chronically sick poor must be supported by charity. Children with tendencies toward disease may grow into undesirable men and women, handicapped by mental or physical maladies. Nor is the economic well-

being of a country ever independent of the health of its citizens. States must, therefore, reckon with medicine in terms of the community and carry the work of social sanitation much nearer the individual.—*Commonweal. Je.* 12, '29. *p.* 144.

The very prolongation of life during the last half-century has added to the burden of sickness. The lives which formerly were cut off in infancy or which were terminated in their early prime by tuberculosis, now pass over, so to speak, into the period when the chronic illnesses of middle age set upon them, when men and women must live with disease instead of dying from it. Postponing the undertaker means more use of the doctor, no longer as a death-bed resource but as a means to more effective living. Longer lives are better than early deaths, but they cost more in terms of sickness bills.—*Michael M. Davis in "When Sickness Hits the Pocketbook." Survey. N.* 1, '27. *p.* 122.

New evidence of the financial straits to which illness drives middle-class families comes in a report of the personal loan department of the National City Bank in New York made at a recent meeting of the Eastern Regional Savings Conference of the American Bankers Association. Borrowers from this department must be at least 21 years old and regularly employed; the greatest number (22 per cent) are clerical employes, followed by salesmen, public employes, department heads, mechanics, and so on down to small groups of professional people; the average amount borrowed is about $350. Of the $40,000,000 lent during the first twenty months of this service, $12,000,000 "was made available in cash to doctors, dentists, and hospitals," according to Roger Steffan, vice-president, "on behalf of patients who otherwise might have had to forego proper care, who might have had to ask for charity, or else delay payment altogether."—*Survey. My.* 15, '30. *p.* 194.

The Endicott-Johnson Corporation—Its 16,000 employes and their families represent a total population of probably not less than 60,000 people. The corporation gives to this group of employes and their families a medical service which includes the full-time services of 27 physicians, 3 dentists, 1 X-ray technician, 51 nurses, and 2 pharmacists, for an annual cost of $25 per worker, or at a cost of $6 to $7 per capita for the whole industrial population.

Roanoke Rapids, N. C.—This industrial settlement, composed of the workers of 5 cotton mills and 1 paper mill, gives a very modern, efficient medical service, including hospital care, home visits, and public nursing, for $23.60 per family, or at approximately $9 per capita.

That the professional work of these organized services, as compared with that of unorganized services, is of a very high order, will be everywhere admitted. The leaders of the profession identify themselves with group practice, i. e., with organized medicine. When sick individually or when families are sick, they resort to the use of an organized service. It is more efficient; it is more economical—*W. S. Rankin, M. D. American Journal of Public Health. Ap. '29. p.* 363-4.

Leaders of the medical profession have not taken the myopic view. As a matter of fact they have been the very prophets and promoters of preventive medicine. The men who have done most to introduce the telescope have with certain notable exceptions been trained primarily to concentrate upon the microscope. With them cure and prevention have been not sharply contrasted but closely related ideas. They have increasingly regarded experience with disease in individuals as a means of protecting the community against it.

The progress of public health depends upon the appreciation, sympathy, and support of the medical profession. Doctors will gradually come to think of themselves

and to be regarded by the public as primarily responsible for keeping people well. Periodic physical examinations, the early discovery of incipient maladies, warnings against environmental dangers, the wise control of diet, insistence on appropriate exercise, suggestions about personal and social life, will in increasing measure replace medicines, hospitals, and sanatoria; may even reduce the demand for surgical service. Who knows but that the doctor of the future, receiving an annual retaining fee from his clients, will feel no embarassment in taking the initiative and in keeping a watchful eye upon them? Then a case of illness would be not the physician's opportunity but a reflection upon his vigilance.—*George E. Vincent in "The Rockefeller Foundation; a Review for* 1921." *p.* 8-10.

When a women goes to a first-rate hospital under the care of a first-rate physician she ought to be assured without any question of every aid that science has devised. Well, she isn't. As a rule she bears her child with the immemorial pain. Absolute cleanliness is the principal advantage she has over her great-grandmother. Considering the bill, that isn't enough.

In most of our great cities there is a steadily declining birth-rate. More than one factor, of course, enters into the situation, but surely not the least important one is that a baby can quite easily cost $1000, and not be registered under the name of Rockefeller, either. But let's drop below this figure and itemize a more ordinary bill. Let's put the room down at $10 a day; that's $140 for two weeks. There will be various extra charges and numerous incidentals not directly connected with the hospital that will bring the total to $200. The doctor's fee is not regarded as very high now if it is $250. Make allowance for extra expenses due to a temporarily disrupted household and the total will be $500. This figure will be familiar to thousands of New York City bookkeepers and clerks.

That's quite a lot of money, I think, considering what it ordinarily buys. It seems to me that it ought to buy all the obstetrical science there is on earth. But if you want it all you must move into the realm of the $1000 specialists. In all this, I submit, there is a violation of sound public policy. It would be all right for monkey gland operations; most of us can worry along without them, but all of us have to be born of women. And the women go on suffering.—*Chester T. Crowell in "Hospitals." American Mercury. N. '28. p.* 281.

I have before me a memorial addressed to the House of Delegates of the American Medical Association by the National Grange, petitioning the governing body of the profession to find some means to relieve the alarming and growing "scarcity of country doctors." They quote some highly significant statistics. According to a survey made for the General Education Board there were in 1906 approximately 33,000 physicians in places of 1,000 inhabitants or less, and in 1924 this number had been reduced to 27,000, a loss of 6,000 rural physicians in eighteen years. More recent investigation show that almost one-third of the towns of 1,000 or less throughout the United States which had physicians in 1914 had none in 1925. The average age of rural doctors throughout the country in 1925 was fifty-two years! Since the average age at death of American physicians is sixty-two years, it will be seen at a glance that the present generation of country doctors will have practically disappeared in another ten years.

"With this situation staring us in the face," continues the National Grange, "it is ominous, to say the least, that only a very small percentage of the medical doctors graduated during the past ten years have taken up the practice of their profession in the rural districts. Careful inquiry reveals the fact that there are literally scores of rural counties in the United States where not a single

doctor receiving his degree during the past ten years has settled."

Meanwhile, the Commission on Medical Education reports that with our present medical school capacity, the graduates averaging twenty-seven years of age, the total number of physicians in practice in the United States is actually decreasing. It is estimated that their number will not again reach the present roll of 130,000 until 1965. In the mean time the population of the country will have increased from 115,000,000 to 164,000,000. —*G. F. van Bibber, M. D. North American Review. Ja. '29. p. 92.*

That most insistent problem of modern life, the steadily mounting cost of medical treatment, has stimulated various projects for its solution. Few are more interesting or more radical than the one embodied in a resolution adopted by the American Medical Association at its recent annual convention in Detroit. It calls for the creation of a Bureau of Economics within the Association, which is to investigate all the factors having to do with the size and the payment of doctor's bills; this will presumably include not only an economic analysis of the items of charge, but also a statistical report on average incomes and average budgets. It is hoped to make the findings of this Bureau the basis of a new social policy of "voluntary collectivism," to be operated, according to the present plan, through the existing county medical societies. The skill and prestige of the members are evidently to be pooled for the benefit of the public unit which each such society serves, and the poorest patients are to be given the most up-to-date medical care for prices within the range of their resources.

It is unlikely that such a thoroughgoing and idealistic project will be transferred from paper to practice without wide changes and qualifications. But as a record of the opinion of a majority of eight thousand physicians representing the whole country, it has a very real significance.

It marks that profession's sense of its continuing obligation to the public, on the one hand, and its mistrust of what may be called legal socialization, on the other. That such socialization is the logical term of the tendency that now prevails cannot be doubted. With fees increasing, and the sense of community responsibility for health increasing also, the physician commandeered and salaried by the government is the inevitable figure of the near future—unless physicians themselves can devise an acceptable substitute. All of this has been boldly recognized by the Association. In writing themselves down as favoring the alternative of "voluntary collectivism," its assembled delegates present not only a plan that invites watching, but two facts that invite meditation: first, their testimony that the growing medical fee has not meant a growing income to the private physician: and second, their conviction the "the salaried physician. . . by virtue of the circumstances under which he must render his services, will not be able to devote to the individual patient that careful study that is or may be required."—*Commonweal. Je.* '30. *p.* 274.

AFFIRMATIVE DISCUSSION

SOCIAL USES OF MEDICINE[1]

In the practice of medicine today is found much that is admirable from the point of view of personal service and community welfare. Ingrained in the system of private medical practice is also much that is chaotic and wasteful, much that is destructive of the best interests of society. Side by side with the glorious spirit of individual self-sacrifice, characteristic of medicine throughout the ages, students of social organization are increasingly conscious today of elements tending toward the perpetuation of inadequacies in disease control, serious qualitative and quantitative deficiencies in diagnosis and treatment, resulting in an inevitable loss to society in preventive and therapeutic potentialities unutilized, and retarding the development of scientific medical knowledge, as well as the elevation and standardization of practical medical service.

Accomplishments of Medicine

Yet marvelous has been the progress of medicine in the last few decades. Great have been the benefits to mankind resulting from unselfish effort and untiring struggle against the captains of disease and death. Many are the trophies of victory won in this fight to lay a firmer physical foundation for economic, social and spiritual evolution. The sanitation of whole countries has made possible the exploitation of the resources of nature. Smallpox robbed of its terrors, yellow fever conquered,

[1] By D. B. Armstrong, M.D. Paper read before Sociological Section, American Public Health Association, at San Francisco, Cal., September 15, 1920. *American Journal of Public Health.* 10:921-31. December, 1920.

typhoid fever reduced to a disease of minor importance in most self-respecting communities—these are a few of the conquests of *preventive* medicine.

Still, the necessary characterization of these accomplishments as preventive, is not wholly encouraging. This is progress in disease prevention, but it is not essentially a reflection of growth in the routine practice of medicine, the diagnosis, treatment and cure of the everyday minor or serious affections. Unfortunately, the same methods responsible for the advances in epidemiology are not applicable to the control of many of the remaining scourges affecting society. Dependent upon still undeveloped methods is the ultimate control of such major factors in our present mortality as tuberculosis, cancer, kidney and heart disease, probably the less specific respiratory affections, venereal disease, etc.

These advances in disease prevention are in fact a direct measure of organization in medicine. They are the result of organized research, of the social organization of medicine through health departments, sanitary commissions, or similar social devices. The type of medical social organization devised to meet these problems has accomplished part of its task admirably. It still has other fields to conquer. Yet without further and different development in the organized social group use of other existing resources and methods for disease control, we cannot hope for substantial progress in many vital fields. As Sir James Mackenzie has put it, in his recent volume on *The Future of Medicine*:

> The next step is to recognize, that if progress cannot be carried further with our present conceptions and methods, we must look out for a new concept, as well as new methods.

Inadequacies of Medical Practice

What is the situation in many fields of medicine today? Investigation shows that 70 per cent or more of any typical population group is in need of medical or dental advice or treatment, for minor or serious ills. How

many are ever brought into contact with corrective medical advice? How many are advised or treated while the affectation is in its incipiency? How many, even when brought under medical surveillance, receive competent and thorough-going advice or treatment? In what percentage are the laboratory and other technical "instruments of precision" for diagnosis and treatment, although theoretically available for all, actually applied? Why do many physicians everywhere, in spite of state provision, still make or fail to make diagnosis of diphtheria without throat cultures, or syphilis without a Wassermann?

Recent surveys have shown that there exists in normal communities three times as much active tuberculosis as is usually under observation. Why is it that in most communities 20 per cent of the tuberculosis cases first come to the knowledge of the health authorities when reported at death? How infinitesimal is the percentage of surgically curable cancer that is detected in time? What health officer is bold enough to claim that even a substantial proportion of the venereal disease in his community is receiving adequate medical treatment? How many adults or children in the typical urban population ever receive an annual medical inspection admittedly essential to the detection of early disease and the promotion of hygienic living?

The present method of unorganized private medical practice, devoted and conscientious as are the rank and file of the profession striving *individually* to meet these problems, has been tried and found wanting. Real progress in all allied fields has been concomitant with some degree at least of social organization. Can private practice, through socialization, be converted into a far more effective social instrument?

We all know that the individual in the system is not responsible for this seemingly hopeless and chaotic condition. He is a victim, with those he is seeking to serve, rather than a promoter of the system. The status of medicine today is one of the many symptoms of the semi-

anarchistic, individualistic organization of social life. It shares with other phases of the unsocialized state the glaring imperfections of society. Synthetic-minded leaders in all walks are seeking an adequate program. Indeed, this is conspicuously true in medicine. Unfortunately, here as elsewhere, progress or even the experimentation essentially prerequisite to progress, must be made against the lethargic opposition of many who lack the spacious-mindedness necessary to grasp the significance of the present acute problems of this war-altered world. The problem of utilizing social forces for the physical betterment of man presents many inherent difficulties. Change there must be. Shall that change be radically disruptive or conservatively constructive?

Need for Socialization

As some one has put it, "the whole world is yeasty." Changes are inevitable, changes involving new relations, new social adjustments, new usages for social organization. Now, is it not true that past history shows a tendency toward the development of new social instruments? Certainly this is true of medical history in particular. The great modern advances in disease control, barring a few unpremeditated, unplanned, accidental discoveries by isolated individuals, have been the result of organization, either for laboratory research, field study, or other experimentation. Shall we not therefore find, that in order to solve the major difficulties of medical practice today, we shall have to have a further socialized organization of the forces now wasted or imperfectly used?

Certainly no doubt can remain as to the inadequacy of the present day arrangement, particularly on the side of case treatment. Speaking with international authority Sir Arthur Newsholme says:

> That the work done on behalf of the community, *plus* the work accomplished by private medical practitioners, is not equal to national needs, is obvious to anyone considering the vast amount of avoidable disease in our midst. Why is this and what

is the remedy? . . . The medical provision made in a large proportion of cases is belated and inadequate; it commonly does not include the full resources of medicine; and in perhaps a still larger proportion of cases medical advice is not obtained, or being obtained is not followed. This applies even more to hygienic than to clinical medical advice.

In the face of these difficulties there are those in the medical ranks who would urge that the physician be concerned only with clinical medicine, only with the treatment of individual cases, leaving disease prevention, and the promotion of hygiene and allied problems, entirely to the sanitarian and the social worker. The weakness of this must, however, be apparent to anyone seeing the problem as a whole. It is one problem, a problem of social medicine—a movement that must push forward in a united advance on the bulwarks of disease. We cannot separate the treatment from the prevention of disease without jeopardizing the success of both.

Socialization to Date

At what preliminary conclusions have we therefore arrived? Is not the answer the "socialization of medicine"? Why is this phrase to the average medical man "like a red flag to the Attorney General"? Is the socialization of medicine something new and unheard of? Have we none of it to date? Is it something terrible that is going to befall us over night? Are we being led astray by fools captured by catch-words?

On the contrary, the socialization of medicine began with the earliest clinic, hospital or health department; and has slowly and inevitably broadened in scope and increased in momentum, to the inestimable benefit of the public and of the medical profession itself.

Indeed, the social tendencies in medicine today are following many sound precedents. There was a time, for instance, when most communities got their water supply from individual wells. Then there came a time when a common (social) water supply was found to be

safer, cheaper, and in every way better. Medical service is now passing from this individualistic stage to the stage of social conservation and social control.

Those who object to the theory of "socialization" do not usually oppose its practice. Consider such universally accepted examples as the following:

1. The development of a medical coöperative group method of treating disease—namely the hospital public ward.

2. The establishment of diagnostic and treatment facilities for large social groups, medical equipment and personnel being employed in common—namely, the clinic or dispensary, and all out-patient service.

3. Community health organization, official and private health bodies—representing the interests of the whole community as to disease prevention and control.

4. The employment of medical service for large population groups in society, as for the school children, the industrial workers, etc.

5. The development of group practice and specialty clinics, rendering available diagnostic and treatment facilities otherwise beyond the reach of the average physician and patient as well.

6. The fostering of routine medical examination and advisory work for large unorganized groups of individuals by the employment of organized medical forces, such as through the Life Extension Institute, and other agencies.

7. The preparation of vaccines, sera, etc., by the state, for social use.

8. Finally, and perhaps most significant thus far, the employment of *organized medical* forces, in the development of general *social machinery* for the prevention and treatment of disease and disability, as in accident and sickness insurance, imperfect as is our social organization in these fields at present, inadequate and unsatisfactory as has been the practical provision on the medical side.

Are not these measures more than "a tendency toward the socialization of medicine"? What, in fact, is the "socialization of medicine"?

Before reaching a definition of this term, let us say once and for all that this is not an attempt at the analysis of detailed method in the present medical system. It is more an effort to interpret the existing spirit and doctrine of medical service and disease control. Neither is it the plan to outline and discuss specific recommendations, such as health insurance, for instance. Rather, it is hoped to indicate certain broad lines delimiting the range and direction of future progress. Our interests are not in the theories but in the practical program. Our argument is not for "the type of mind that would rather play with a perfect theory than improve an imperfect world."

What is Socialization?

What does the socialization of medicine mean? Does it not mean the use of medical knowledge and facilities for constructive social ends? This implies the social attitude, namely, the attitude of service.

Now, from this point of view, there are few who will not agree that the practice of medicine, in spirit and motive, is the most socialized instrument for physical betterment at work in the world today. The physician has the spirit of service. He succeeds to the extent to which, through his unorganized individual efforts, he is bettering the lives of others. He possesses the social attitude; his social defects are therefore largely those of method and organization. All that is implied by the term is admirably expressed by Sir Arthur Newsholme:

> The definition of the sense in which I employ the term socialization in medicine—would include the rendering available for every member of the community, irrespective of any necessary relation to the ordinary conditions, of individual payment, of all the potentialities of preventive and curative medicine.

Impending Social Developments

We need not be concerned over the spirit of service essential to this object. It is there and always has been.

How can medical facilities be organized practically, for the attainment of this end? That is the great problem, upon the solution of which real progress in further disease elimination depends. Still, do not all the current manifestations of socialization previously discussed bring us several steps further in the direction of the goal? Are we not on the verge of fresh developments in this same direction? What, in fact, are the impending developments in the social life of medicine through which we may hope to see the methods of medical practice more nearly approximate the admirable social spirit which inspires the medical world? Perhaps a few of these "next steps" may be indicated as follows:

1. The further development of public and private health organizations, using their machinery for disease control, for the elimination of non-communicable and degenerative causes of disease and premature death, such as cardiac, nephritic, and other affections, as through dietary education, cardiac classes, etc.

2. The further development of adequate training for medical men in medical schools in the science of disease prevention and early detection, the principles of hygienic living as well as the treatment and cure of specific cases of disease.

3. Adequate post-graduate instruction, providing a means for continuous, up-to-date contact with the more recent medical discoveries, possibly involving periodic re-examinations on the essentials of diagnosis and treatment—thus strengthening the relation between the state and the physician with the object of better medical service.

4. The extension of clinic and dispensary medical facilities on a pay basis for wider groups in the population—a further socialized use of the clinic method.

5. A great extension of organized, age-group diagnostic and advisory work, bound to come in the near future, including full-time medical, dental, nursing and clinical personnel and equipment for school children, in-

dustrial workers, etc., and providing facilities for routine medical examinations.

6. Organized efforts to provide annual medical examinations for the population at large, through such agencies as the Life Extension Institute, medical examination clubs, national medical examination campaigns, etc.

7. The development under government auspices of expert itinerant advisory and consultant service for the general practitioners on diagnosis and treatment, covering difficult and doubtful cases in many of the specialties such as tuberculosis, infant welfare, internal medicine, etc.

8. Possibly the districting of medical service, at least to meet epidemic emergencies, leading perhaps to the setting up of competitive standards of excellence, graded on a basis of disease prevented and health maintained.

9. The reincarnation of the "old family physician," as the guardian of the family's health and the teacher of family hygiene—the treatment of the family to be carried out on the "keep well" basis, a practice erroneously said to be common in China, but one which shows definite signs of development in this country.

10. The further and more equitable development, as an experiment at least, of accident and sickness insurance, merely an item in the whole program of socialization, but one around which centers most of the storms of discussion at the present time.

Handicaps of Present-day Practice

"The physicians are opposed to the socialization of medicine." Any one will tell us that, but is it true? Certainly they do not like the term. Certainly they do not favor health insurance. But that is only one aspect of the tendency so manifest today. Any one who has had any experience with the initiation of practically any of the phases of socialization enumerated above, with one or

two exceptions, will testify that the physicians not only are in favor of the measures, but give them full coöperation and hearty support.

In fact, it would be difficult to imagine why the physicians should be opposed, why they should approve the *status quo*. Surely they are not in love with present conditions. The doctor accepts his lot with superior good-will, but he works in the face of almost intolerable obstacles. A few of the disagreeable elements which, to a great degree unnecessarily, burden the life of the general practitioner are:

1. More than any other occupational group the physicians are called upon to meet the demands of long hours, excessive over time, night work, etc.—all, with relatively few exceptions, for a "white wing's" pay.

2. Not only is he under-paid for the services he performs, but the doctor's collections are frequently poor. It is considered poor etiquette to be too "business-like" in insisting upon payment and he faces the subtle public sentiment that rather discredits the man in medicine who "makes money"—a condition that prevails in no other calling.

3. He is required to maintain the morale of the soldier—takes the risks of the soldier—yet there is for him no remuneration while in training, no promotion, no pension, no discharge—a life with the severest duties and with few rights.

4. From him is demanded more volunteer service, without compensation, or recognition, than is the case in any other profession.

5. While he may have been an excellent student in school, an enthusiast for research, a man who had genuine scientific interests, the economic pressure to which he is subjected in practice will not only give him no chance for continued study, but will often dull his sense of scientific values and his enthusiasm for worthy endeavor.

6. If a general practitioner striving to develop a specialty, he has to fight for every minute of time to

study. Then, he must face that part of the public that sneers at specialists, and at the same time expects to find for a dollar office call all the specialties combined in one man—a surgeon, an ophthalmologist, a pediatrician, a tuberculosis expert, and what not, never realizing, in the words of the old adage, that "a jack of all trades is master of none."

7. Economic pressure, again, will probably prevent the devotion of his time and interest to the work for which he is best fitted. How many potentially excellent neurologists or research men are wasting their time on routine life insurance examinations, to eke out a living?

8. If he has devoted years to thorough training, he is still likely in some communities to find himself in competition with a graduate of a correspondence school or a night diploma mill.

9. He may start out with high ideals of service, with the desire to keep accurate records, anxious to meet his full obligations to his patients. How often does one see these early ideals recede with the hard earned knowledge into the dim past, in the face of competitive economic pressure for a living? How many men would like to keep accurate case records if time allowed? How many would like to act according to their conscience and perhaps call more frequently upon patients, if this did not have the appearance of selling themselves and forcing their services? How many would like to follow up their cases, preventing possible serious sequallæ, if time and custom permitted?

Glories of the Profession

This is the practice of medicine, except for the favored few. Does it mean an easy existence for the physician? Does it mean the best service for the public? Yet in spite of these handicaps, we find in every community many medical men performing a noble service under a tremendous burden. There is scarcely an Amer-

ican community without its old family physician, interested in all good movements, trusted with leadership in all vital matters, struggling along in poverty, concerned only with his obligations and opportunities for service and self-sacrifice. His example brings to us a realization that these limitations upon practical medical service, while they represent just grievances, are equally significant in reflecting the glories of the profession. . .

Objections to Social Medicine

What indeed are the practical objections offered by physicians and others to these progressive developments in medicine? Consider only a few of the arguments presented against the social movement, arguments directed generally against the extension of social insurance, this being the line of social development most conspicuously and energetically promoted at the present time.

1. The injection of the state into the affairs of medicine will interfere with the normal relations between the physician and the patient.

Yet we have seen that this relation is largely an economic one, very unsatisfactory for both the physician and patient. The physician comes into contact with the patient only when called. He does not follow the case to a complete cure unless the patient bids him so to do. To force his services when he alone may know how absolutely essential they are is out of the question. There is, in fact, in the existing relation very little to insure the proper care of the case, the protection of society, or the proper remuneration of the physician. There is a tremendous opportunity for improvement in this relationship. Indeed, if the present relation must be accepted as the "normal relation," then something decidedly abnormal would seem greatly to be preferred.

2. So-called "state medicine" would seriously interfere with the physician's income.

Yet everyone knows how meagre and uncertain is the income of the average physician today. Besides, it is a

reward for the amount of illness in the community, and not compensation for the amount of health preserved or created. Further, at present the physicians are performing only a fraction of the amount of work that needs to be done, and that will never get done under present conditions. For the additional preventive and creative work that should be undertaken under a reasonable arrangement, there would be supplementary remuneration for the medical profession. Socialization would quadruple the "business" of the profession.

3. Socialization would level downward.

A wise plan of state medicine, placing reward for service on an emulative basis, with a system of promotion from less important occupations (or possible districts) to more important ones, the standards being disease prevented, sickness cured and health created, would eliminate the unfit, elevate and standardize practice, increase compensation, and level upward rather than downward.

4. Socialization would eliminate "personality" from the service.

It is true that certain steps toward socialization thus far developed do depreciate somewhat the value of personality. In hospital service this is undoubtedly a factor, the public wards being less attractive because of a relative lack of choice of physicians on the part of the patients.

Certainly, any wise system of public medicine gradually and cautiously developed along lines previously indicated, must recognize the "art" as well as the science of medicine, and must take every precaution to preserve the value of the personnal elements. Of course this "personality" factor has disadvantages as well as advantages. The poorly trained quack frequently has more "personality" than the scientifically trained physician. On the other hand, higher and more uniform standards of training and practice would minimize the importance of the personal choice factor. There would be a leveling upward as to medical proficiency. Further, after all of the physicians, with the incompetents eliminated, were properly related

to the community and the community's treatment facilities, such as hospitals, clinics, etc., there would be no question of inadequate hospital and medical relations, physicians without hospital connections, etc.

5. State control over the practice of medicine tends to make patients a litigation problem (particularly in health insurance) rather than a scientific problem.

In the first place, such a result could not fairly be called "socialization," for the primary aim of current social tendencies is to increase the scientific treatment of will fall back on the state, exaggerating trivialities, adopt-illness, to render more available the existing instruments for diagnosis and treatment, and to decrease the percentage of cases that go untreated altogether, scientifically or otherwise. As a matter of fact, the ordinary every-day practice of medicine as carried out at the present time could scarcely be made less scientific.

6. State control would make "the case" purely a scientific problem, ignoring the human factor.

This delightfully contradictory objection is often stated in the same breath with the one preceding, and answers itself.

7. Socialization tends to break down individual self-reliance, self-respect, and the willingness on the part of the patient to meet his own obligations.

It is claimed that of all the people needing or not needing treatment in a community, if treatment facilities are made too readily available and attractive, there will be a certain percentage who will take unfair advantage of the opportunity. These people, either not in need of treatment or quite able to pay adequately for private care, will fall back on the state, exaggerating trivialities, adopting malingering tactics, etc. According to the argument this is a load the state cannot afford to carry.

On the other hand under present conditions 70 per cent or more of our population is in need of treatment, and largely fails to get it. This represents a much greater state liability and one which the state can much less afford to carry.

8. There will result a tremendously expensive and unwieldly political machine into the unsympathetic arms of which medicine will fall.

As a matter of fact, the largest element in such organization as may be necessary to administer the program of social medicine, would be the medical profession itself. Errors in the plan, defects in the provision for medical work, vicious manipulation of the system as a whole, can all be eliminated by the medical profession itself if it gets into the game in the beginning, shapes the development of the program, and contributes its constructive genius to the further growth of the whole system.

Undoubtedly it is up to the physicians to take the lead and initiative in the development of the social control of medicine. The movement should be governed from the inside and not from the outside. In this way only can the adequacy of the plan from the medical point of view be assured. Very significant is the statement of an English authority on this point (Sir Arthur Newsholme).

> It is, I think, clear that the state will year by year take an increasing hand in medical matters. It is useless, even if it were desired, to attempt to oppose the inevitable and desirable trend towards a vastly increased utilization by the state of medical science in the interests of humanity. It is for physicians to guide the course of events, and to insure that no plant is sown which will afterwards need to be uprooted; that no development is permitted which will hinder the fulfillment of our ideal.

Benefits of Socialization to the Physician

A few of the many advantages of a further social control of medicine to the private physician may be summarized briefly here. A social system properly planned should insure more regularity of service as to hours, a tremendous increase in the amount of worth-while work accomplished, an enhanced income, a reward on a rational basis of accomplishment, better opportunities to study and specialize, opportunity for expert consultation and coöperation, and the elimination of the necessity for

frequently putting economic consideration ahead of the patient's welfare.

The individual trained to treat the ills of his fellowman should be assured of an adequate income, not dependent on a chance excess of illness in his community. In medicine the relative cost factor should be eliminated both for the patient and the physician. Society cannot afford preventable illness. Society cannot afford to leave its elimination to a haphazard system in which the patient and the doctor make their decisions under the pressure of economic necessity. This ideal is approximated even now in one form of socialized medical service, namely, the hospital. Here there are, for instance, laboratory and research facilities for all, rich and poor alike, and the cost factor is partially at least eliminated, the basis being service. The socialization of medicine should eventually eliminate from the physician's life this hampering element of economic pressure. The man who is teaching medicine as well as the man who is practicing it, should be free from worry and undue stress on the side of self and family maintenance.

Benefits to Society

Equally obvious must be the advantage to society. Through socialization in its many phases, every individual should receive the advantages of special facilities and expert service, regardless of his paying ability. From the social point of view, preventable sickness always is too expensive. We could afford to obtain medical service at any cost for the 70 per cent in need of it, and not only for the few who can now afford it. If it is cheaper "to prevent than to cure," and if "a stitch in time saves nine," then the prevention, early detection, and adequate treatment of disease will materially lower the charges upon the community for illness costs. Finally, society would be operating on a rational, economically sound basis, utilizing its medical resources to the full.

IN DEFENSE OF SOCIALIZED MEDICINE[2]

Over a million persons devote their entire time to the cure and prevention of disease and to the preservation of health of the American people, and yet complaints are numerous as to inefficient and insufficient medical aid. There are many small communities without any medical aid at all and their number is increasing. There is a continuous development of medical quackery and cults. The patent-medicine trade continues to flourish. Self-medication is popular. Every health survey discloses a great proportion of existing illness uncared for. And it is the frank admission of the medical profession itself that most of the practice is not scientific.

What is the trouble? First, the average state of knowledge of the practitioner of medicine is tragically behind the present stage of medical science. There are some 150,000 independent practitioners in the art of medicine whose contact with modern medical science may be anywhere from one to fifty years old. Yet once authorized to practice medicine, the physician preserves this authority over our health, life, and happiness, even as a deed remains a permanent letter patent over a certain piece of property. For the license to practice medicine is a property right and is logically to be considered such as long as the basis of our organization of medicine is the system of private practice, the income-bearing possibilities of a medical diploma and a medical license. This medical diploma and license confers upon every physician—every one of the 150,000—the right to cure all the ills the human body is subject to. He may practice all branches of medicine from obstetrics to brain surgery, from ophthalmology to proctology. Now, it is a safe assertion that not a single one of the 150,000 is competent to perform all the services which legally he may undertake. Yet the

[2] From article by I. M. Rubinow, Director of the Jewish Welfare Society of Philadelphia. *Nation.* 126:508-10. May 2, 1928.

organized state has not seen its way even to limit the healer's license somewhat more closely to the performance of what he is really competent to perform.

For their protection, 110,000,000 patients are themselves expected to pass judgment as to the comparative merits of their physicians and surgeons. Now, it is hard enough to be an expert on the million and one material objects and services which everyone of us has to purchase in the course of our daily existence. But how are you to judge as to the knowledge, skill, and wisdom of a physician? By the results? I challenge any statistician to work out a satisfactory basis. So we judge by rumor, appearance, personality, display, disguised advertisement, and bluff. In short, in the selection of the physician, the chance of obtaining competent medical aid is largely a gamble, a speculation, with the patient's health and life at stake. And no one better recognizes it, no one more forcefully admits it than the physicians themselves. But not openly, for that would be against professional ethics. Officially, the fiction persists that one reputable physician is as good as another, for they all have the right to sign death certificates.

Secondly, the practice of the art of healing today requires not only an amount of knowledge which, because of its very vastness, must be divided among many but also a vast installation of machinery and apparatus; in short, a capital investment as well as skill. Hospitals and dispensaries, clinics and sanatoria, convalescent homes, laboratories and X-ray departments, institutes of hydrotherapy, electrotherapy, mechanotherapy, etc., assistants, bacteriologists, pathologists, radiologists, chemists, nurses, etc., there are the mechanical elements and human elements of the necessary medical organization for practicing the art of healing. Contrast all that with the average facilities of the private physician, not only with those of the general practitioner but even of the modern specialist.

The practice of medicine has grown beyond the powers of an individual physician. It is being organized and, to a very large extent, institutionalized. Already some 7,500 hospitals provide 800,000 beds, representing an investment of approximately $5,000,000,000. There are some 6,000 dispensaries and clinics. Perhaps an increasing proportion of the American people receive all their medical help in these hospitals and clinics and dispensaries. But the curious anomaly is that economically private practice remains the form of organization.

There remains a third serious indictment of the system of private practice and the principle of private barter and bargaining, the cost of medical aid and care. The slogan "The very rich and the very poor are the only ones who receive the best kind of medical help" has become almost a bromide, so frequently is it quoted when the problem of medical organization is discussed. Like all slogans, it contains a half truth. It is, undoubtedly, true of the very rich. And only of some poor, those who are fortunate enough to be admitted into a first-class medical institution. For the vast majority of our people, a serious illness is a financial as well as an emotional catastrophe; the cost of cure is ruinous if not prohibitive. It is unnecessary to quote figures. No figures would be typical. But every American can quote illustrations from his own experience or that of his friends. What does a pneumonia cost? What an appendicitis? What the arrival of a new member of the family? What is the average price for any of the thousand different diseases, acute and chronic? There is no standard of cost. It varies not only with the locality but with the economic status of the patient and his family, with the particular notion, no matter how inaccurate, as to this status which the physician or hospital may form, with the commercial talent of the physician, with the particular valuation which the latter places upon his services, etc. What else but chaos may

one expect in the price of a commodity, about the quality of which the purchaser has no way of forming judgment, but which he is more or less under compulsion of pain and fear of suffering and death to purchase in a hurry at a particular time? There is perhaps no other example in which the case for price-fixing is so strong, yet no step has been taken in that direction. Compare the excitement which almost precipitates a revolution among 6,000,000 people because of a threat of increasing the carfare from a nickel to seven cents. Governments may fall and, for all we know, barricades may be built in the streets of New York City unless this problem is satisfactorily settled. And what are its implications—a difference of four cents a day or $10 per annum per worker. But whether an appendicitis operation is worth $50 or $500 or $5,000 seems to be nobody's concern.

Now, it is not at all necessary to look for panaceas or even "dangerous" social experiments for a way out of this tragic situation, where the health and life of individuals and even of entire communities have become a matter of barter and sale. The way out lies in the direction in which the practice of medicine is inevitably tending.

The forces which must be called into action are threefold: (1) Institutionalization; (2) Organization; (3) Socialization.

And of these three words, the third is the one which works as a bugaboo. Do what you will, there is a dangerous connotation in it. It is almost like a conditioned reflex, which makes a patriotic American shrink or jump, according to temperament, when this word is thrust at him. It might be an interesting field of investigation for Pavlov, Watson, or any modern psychologist, as to what particular part of this dangerous word is responsible for the effect. One is tempted to revive the hoary anecdote of the Russian censor who prohibited Lester Ward's "Dynamic Sociology," claiming that the book dealt with dynamite and socialism.

SAN FRANCISCO TUBERCULOSIS ASSOCIATION

There has been a good deal of objection to institutionalization of medicine, but this objection has been largely overcome. Opposition to free hospitals and clinics, and even to low-paid clinics as dangerous competitors, crops out among physicians now and then. But, on the whole, the medical profession has learned to tie up medical institutions to the prevailing system of a private practice.

Of course, institutionalization presupposes a great deal of organization, but organization is necessary and is growing even outside of institutional practice. Private practice is not as individual as it was some time ago. The dependence of a general practitioner upon the specialist for expert help, the dependence of the specialist on the general practitioner for patients, the dependence of both the general practitioner and specialist upon laboratories for diagnostic help, the dependence of all the above upon the private patient (with money!) for a source of income, indicates the high degree of necessary organization. "Group practice" is one of the many experiments in this field of organization. In absence of such, the organization is a crude one and for the suffering patient, an expensive one. He is driven from pillar to post, from one specialist to another, paying an exorbitant rate for the laborious gathering of the necessary information as to his condition, which in a well-equipped institution can be had at an infinitely smaller expenditure of time, effort, and money.

But what of "socialization"? Just what does the dangerous label imply? What is its content?

Whatever the word, what is necessary is an organized cooperative method of providing efficient, scientific medical advice and aid, at a lower social cost, and certainly at little or no cost at all to the patient at the time he is ill.

Does that sound radical or revolutionary, dangerous or socialistic? Are there not enough precedents in the supply of other social needs? Are there not enough

precedents in the field of public health and even medical aid as well?

The field of public education is a very good illustration in point. There is no prohibition of private and individual education by private agreement and for a fee, there is no restriction of "private practice" in education, at least not in any democratic civilized country. But as it is considered socially of very great importance that every child be given a minimum of education, a public system of free education has become a self-evident necessity. Every child may take advantage of the system of free education furnished at public cost. The vast majority of them do, as a matter of course. Side by side with this, private educational institutions and even private individual teaching continue to exist and even to flourish. But a system of public, socialized education is a modern necessity.

Why do not the same considerations hold good for medical aid? Public socialized medicine need not be monopolistic and exclusive. It is not exclusive even in communistic Russia, popular misinformation notwithstanding. Private practice as such is not prohibited even to the physicians who are employed by the state. Nor is the principle of free medical aid at public expense unknown in this country. Hospitals and dispensaries furnish it. Municipalities and states and governments furnish it to a large degree.

Why, then do we not speak of socialization of medicine as an accomplished fact rather than an ideal or a menace in this country? Partly because we are afraid of both the concept and the term. But more properly, because all the free medical work done here is permeated with an atmosphere of charity, because underlying it are the concepts of special consideration for the poor, the indigent, the economically dependent. There are, therefore, numerous restrictions, legal and moral, as to the rights of the individual to avail himself of these free

services. These are all concepts which have disappeared entirely from the field of public education.

The difference is interesting. It may offer a fruitful field for investigation, in search of psychologic explanations. The encroachment of organized society on the field of private medical practice is resented not only by the group immediately concerned—the 150,000 physicians—but to some extent by public opinion, that uninformed and unreasoning public opinion which accepts the medical profession's point of view of medicine as a trade or a business, and a profitable one at that, rather than a public necessity and, therefore, a public service. Instinctively, it draws this artificial line of distinction between education and medicine, because education has been and has remained a poor man's job, while medical practice has paid, in some cases, very handsomely—so handsomely as to establish that profession side by side with law as one of the possible roads to substantial fortunes.

Usually the arguments voiced against the further socialization of medical practice are noble and altruistic. There are the menace of socialism and the defense of the great American principle of liberty. And there is the threatened deterioration of medical science if physicians become wage slaves. And, of course, there is the danger to the principle of free choice for physicians. And the necessity of preserving the intimate personal relationship between physician and patient, and so on and so forth. And, of course, one does not need to be a very profound student of Freud and modern psychology to recognize all these arguments as the most transparent kind of rationalization.

What is there so peculiar in the education, training, make-up, and work of the physician which makes it impossible for him to work for a salary as most of us in other professions do? Salaries have not prevented university professors from doing research in laboratories

and judges from rendering just decisions. Already our greatest medical research and teaching institutions realize that a salary—and, of course a generous one with exclusion of private practice—is the only condition under which devotion to research and to honest hospital work can be assured.

And, of course, the weakest but the most interesting arguments against socialized medicine are those based upon the sanctity and intimacy of the doctor-patient relationship. To begin with, there is absolutely no reason why public or socialized medicine should destroy intimacy of that relationship or even the freedom of choice of that physician. There is nothing in the principle of free medical practice to justify that fear. Under such a system, as under the present system, there will be popular and unpopular doctors. Then, as now, this popularity or lack of it will often result from fortuitous circumstances, entirely independent of professional competence. But what the opponents of socialized medicine close their eyes to is that the old, sentimental, doctor-patient relationship is rapidly disappearing—in larger communities it has practically disappeared already, not through the influence of the free dispensary but through the commercialization of private practice.

The old family physician was a noble, picturesque, delightful figure, but no vain regrets will keep him alive or revive him. Considerations, both professional and economic, drive an increasing proportion of young physicians into specialties and thus widen the sphere of the individual doctor's activities, at the same time destroying the old family-doctor relationship. The constantly rising scale of medical fees, the constant complaints of the masses against the cost of medical aid, the high proportion of unpaid bills, the necessity of seeking the help of collection agencies, the propaganda for application of business-like methods, all this may be inevitable but is hardly calculated to preserve the role of the family

physician as guide, philosopher, and friend, as well as doctor.

And, after all, humanity is not so stupid as to be unable to see the tremendous advantage of a system under which the physician who examines and treats us has no interest in our pocket-book, in our ability and willingness to pay, no interest in recommending repeated calls or surgical procedure because of the promise of a fee, no other interest, in fact, than the professional interest in our symptoms, in their underlying conditions, and in the possibilities of overcoming them.

STATE MEDICINE: BOON OR BOGY?[8]

The time has come seriously to consider the institution of state medicine. By state medicine is meant, not a system retaining all the deficiencies of the individualistic competitive form of medical practice such as the panel system of Great Britain or the sickness societies of Germany, but an organization based upon the economic principle of the division of labor and designed to insure coöperation in supplying a public necessity; to wit, a complete, free, in time compulsory, health and accident service maintained by each Commonwealth. It would necessarily embrace the present departments of public health and of industrial accidents. It would furnish for all who accepted its benefits the same service as that provided by the medical corps of the Navy for its personnel.

Today, health is recognized as of prime importance. Since scientific medicine can do so much to promote, preserve, and restore health and vigor, no one should be denied its full blessings. Yet, at a time when the right of every citizen to the possession of *optimum* health

[8] From article by G. W. Haigh, M.D. *North American Review.* 227: 193-200. February, 1929.

should be esteemed as inalienable as his right to the pursuit of happiness, under the prevalent expensive competitive form of medical practice many do not enjoy its greatest advantages. Even though more than a decade has elapsed since an eminent physician and sociologist writing in a lay periodical showed that the great middle class was not deriving commensurate benefits from modern medicine, nothing significant has been done to remedy this flagrant social defect. And why? Simply because nothing will avail but a radical change from private individualistic practice to a government coöperative health and accident service.

To many, such a proposition smacks of Socialism. But let them reflect that after the need for public education was generally acknowledged, the idea of offering to all children free instruction was no more socialistic. Whereas education concerns only a part of the people only a part of their lives, health concerns all the people all their lives. Since, moreover, there is no constant or exact demarcation between preventive medicine and curative medicine or between private health and public health, private health becomes a matter of public moment as soon as private agencies are found to be wanting. Since the medical profession has signally failed to furnish proper service at a reasonable cost, it behooves the people to provide for themselves the needed organization. As a matter of fact they have already established government departments for the care of patients with mental diseases, tuberculosis, and in Massachusetts cancer. To forestall the successive founding of independent state hospitals for chronic rheumatism, heart and kidney diseases, and diabetes, however, it is positively imperative that they forthwith contrive a free, unified and coordinated health service.

Such a public service obviously would demand, as our public schools do, that its beneficiaries forego their choice of any individual physician and accept the offices of the one or more medical men designated to serve them. This

would not entail any hardship but would be a distinct advantage in this day of specialization, when most persons have to be directed to the source of the best treatment without the delay that so often results from their having exercised this privilege. Surely the doctor is far better able to judge where the most prompt diagnosis and the most effective treatment can be obtained than are the patients themselves, who now wander from one rival physician to another without relief till at length they reach the hospital beyond cure. Already the physician or surgeon engaged in hospital practice is losing his identity; for whereas formerly the common inquiry was, "What doctor did you have?" today it is, "To what hospital did you go?" Formerly, persons might be served by their family physicians from birth to death; nowadays they are brought into the world by obstetricians, attended by pediatricians, operated upon by rhinologists, examined by school physicians, treated for broken bones by orthopedists, operated upon for appendicitis by general surgeons, examined by factory physicians; subsequently, they may consult cardiologists and specialists in diabetes; in the mean time they have without doubt required the services of the Roentgenologists, dermatologists, and dentists. Is it not quite evident that in such a jumble of divided responsibilities, in order to take the place of the vanishing family physician with his intimate knowledge of the patients and the patient's family, there is urgent need of some directing and correlating agent and complete permanent health records?

Since the specialties are bound to grow and multiply with the progress of civilization, which begets new knowledge and new ways of applying such knowledge, the sooner they are coördinated, the better and the easier. Only by organization can they be properly joined for efficient coöperation. For some time coöperative medicine has been practiced in hospitals, especially among the charity and the wealthy patients, when the expense of such has not had to be taken into account. The

superiority of such cooperative practice over the individualistic form was implied in the statement of the previously mentioned famous clinician and teacher, that the large middle class who did not or could not avail themselves of such team work in the practice of scientific medicine were not receiving the greatest possible help. Since such service is too expensive for the working people who are accustomed to pay their way, it can be furnished only by a government medical corps.

The ability of such a corps to maintain the present high standard and steady progress of scientific medicine, however, is doubted and even denied by many conservative doctors and laymen. They assume that individual competition is requisite as a goad and that initiative is repressed by orderly coöperation. Now in any profession to which only the learned should belong an opportunity to work intelligently, itself, suffices as a stimulus to effort. A decent living is sufficient material compensation. For several decades, in fact, most contributions to the advancement of medicine have emanated from clinics, laboratories, or institutes manned by salaried personnel working together. Even members of the medical profession financially independent have shown initiative and energy in the pursuit of such scientific research or in the establishment of renowned clinics. Since 1916, furthermore, the high professional standing of the medical offices of the United States Navy as well as those of the Army and Public Health Service, has been acknowledged by the American Medical Association to be above that of civilian physicians in general, because the former are admitted to fellowship automatically, by virtue of their commissions, whereas the latter are eligible only by meeting certain conditions. Since only representative graduates in medicine enter these Federal services, the organizations themselves must foster a grade of practice higher than that of civilian doctors, who are embarrassed by monetary considerations and distractions in their struggle for a living. Moreover, it was to be observed by

those physicians serving in the Navy for the duration of the World War that the naval personnel had the utmost confidence in its medical officers. Some of those who were financially able and physically free to consult eminent civilian doctors gladly availed themselves of the services of their medical officers.

Another objection to government medicine is its alleged prohibitive expense. Just reflect upon the extravagance of the present incoherent multifarious health agencies in Massachusetts. First, there are the state organizations, including the Commission of Public Health with its manifold divisions, with field and hospital forces of mental diseases, tuberculosis, communicable diseases, cancer, bacteriological and serological laboratories; the Department of Public Welfare with its hospitals; and the Industrial Accident Board with its medical problems. Second, the Federal health services, public health, child welfare and maternity and also various private national societies and institutes of hygiene and medicine with state branches. Third, the local board of health with its hospitals for contagious diseases, and the school health department, ambulance service, diverse hospitals, municipal as well as private, charitable and industrial, general and special, different health centers, district nursing societies, Red Cross workers, private physicians and nurses, pharmacists, masseurs, cultists, mediums, quacks, abortionists, herbalists, fakirs, and dispensers of patent medicines. To what the total expenditures of these multitudinous factors amount transcends the imagination. They are as prodigious as prodigal in comparison to the probable cost of a system arranging and uniting the many diverse worthy agents and eliminating competition in a public necessity more important than all the public utilities. The expense of the latter would prove to be as much less than that of the former, as its efficiency would be greater.

As the value of hygiene comes to be better appreciated and as the progress of civilization renders mankind

economically more and more interdependent, the functions of the civilian physician become identical with those of the naval medical officer, which are primarily to keep the personnel fit for duty, and secondarily to restore them to fitness for duty. Without an excellent organization the medical corps of the Navy and the Army during the World War would surely have broken down under the strain of the sudden and vast recruiting of their respective numbers. That they met that supreme test nobly, no one would dispute. Then why can not that organization be applied to civilian practice? To serve effectually the civilian population relatively immobile and constant, in contrast to the mobile and variable naval and military forces, would be a far less difficult task. Actually, it would be found to possess such reserve capacity as readily to cope with the human disasters caused by storms, floods, accidents, or conflagrations.

In the application of such an organization as the Bureau of Medicine and Surgery of the Navy to the public in general there arise three questions of interest: the method, the cost, and the efficacy. Of these the first two, being rather technical, will not be discussed in as much detail as the last. Moreover, since a way is always found for bringing about a needed reformation, the first two are of less immediate importance than the last.

In the adaptation of this government medical service to the public the unit would be the district hospital with such different departments as eye, ear, nose and throat, orthopedic, obstetric, pediatric, neurological, mental, convalescent, and incurable. It would vary in size according to the populousness of its territory. In the largest cities the different departments might be represented by institutions separate from one another but closely affiliated with the general hospital, which would serve as a clearing house for patients and as headquarters for the personnel and the health records. Besides, there would be auxiliary health and accident stations in factories and shops where enough people were employed, and also in rural communities too remote to be served directly by the central

hospital staff. Temporary relief stations might be set up for celebrations, exhibitions, athletic contests, and entertainments when people collected in large enough crowds. Mobile field companies might be dispatched for service among communities stricken with epidemics or catastrophes. Medical officers on the hospital staff would minister to those unable to visit the out-patient clinics, whether or not in need of hospital treatment. Eventually, however, all patients incapacitated by curable diseases or remediable injuries would be confined to the appropriate hospitals.

Over these medical groups would be a central professional bureau like that of the Navy. This would be manned by medical officers and hospital corpsmen under the direction of a surgeon-general, who alone would be appointed by any layman. In order to eliminate politics from the operation of this service he would be selected by the Governor only from those medical officers of the one or two highest ranks. This State Health Department would encompass the existing Commission of Public Health and the medical duties of the Industrial Accident Board and the Department of Public Welfare.

The personnel would comprise three bodies: medical corps, composed of doctors of medicine; hospital corps, of nurses and technicians; and auxiliary corps, of non professional employees under the civil service. The professional members would have a pay schedule similar to but slightly lower than that of the naval medical officers, who require somewhat more money than civilians because of having to perform duty away from their families. The salary with the usual allowances for living quarters would be determined by two factors, the length of service and the rank. Promotion would be governed up to a certain grade by seniority, beyond that by examination. Bonuses would be given to those performing their duties in an exceptionally meritorious manner or making notable contributions to the progress of medicine. There would be provided, also, insurance against disability on account of health or accident and a pension for retirement.

The funds for the maintenance of state medicine would be obtained from about the same sources as those for the existing medical agencies. People with taxable incomes might be assessed a small percentage of their incomes for this purpose. Those who accepted the free service would be directly compensated; those who could afford not to accept it would be indirectly compensated by not being obliged to contribute to any medical charities. Industry would be taxed about what the workmen's compensation costs, less two portions, the one expended upon the payments for disability of injured employees and the other allowed as a profit for the insurance companies. If the Government or the employers, themselves, handled the insurance against lost wages of employees, the saving resulting would add to the funds. Private life, health, and accident insurance companies would be charged for medical reports furnished them for the issuance of policies and for the payment of claims. Private medical charities might assign their endowments and their plants to the Government at nominal prices. Any payments for temporary or permanent disability arising out of illness or injury being extraneous to this medical proposition, would be made by a separate insurance department or by private companies.

How well state medicine patterned upon the available precedent offered by the Bureau of Medicine and Surgery of the Navy would function will now be shown. It would supply to any and all a free, universal medical service, which might be just as compulsory as our educational system, since no patient should be permitted to lose his life or health through ignorance or fanaticism. Satisfactory substitutes would have to be recognized, since the wealthy might continue indefinitely to employ private physicians and nurses. They would be compelled, though, to comply with the accepted standards, as are our private schools. Those individuals not sufficiently educated and morally fit to administer to the sick and the wounded, it would largely eradicate, directly by exposing them with

impartiality and with no personal profit to the profession itself, and indirectly by providing an organization which would assure harmonious coöperation in proffering to the public the full blessings of up-to-date medicine.

State medicine, furthermore, would remove for many the present inhuman impediment to prompt diagnosis and effectual treatment; namely, the expensiveness of competitive medicine, which has instigated the formation of a private commission of nationally prominent persons to investigate its causes. In many instances, nowadays, necessary operations upon children are postponed for purely financial reasons. Too many tired housewives and harassed fathers must forego the cure of annoying impairments because of the forbidden cost. In some cities the member of the middle class with self reliance pays ten times as large a fee as he ought because nine others without self respect pay nothing. People with precarious equities in their homes are often inequitably compelled to pay for services rendered to their families, whereas those with intangible property escape payment.

It would assume entire responsibility for returning patients to work as expeditiously and as impartially as possible. The conscientious would be discouraged from resuming their occupations too soon, the dishonest would be discouraged from prolonging their convalescence unduly. It would insure patients receiving an examination at the end as well as at the outset of any illness or injury severe enough to keep them from their usual duties. The final examination might disclose defects that would indicate a change of habits or occupations. Nowadays the unintelligent and the parsimonious are willing to spend money upon ineffective, even harmful therapy, but unwilling to pay for a thorough examination uncovering the root of the trouble. Free medicine, alone, would not only make available to every patient all the resources in knowledge and skill of the whole system, but would also supply the means by which they would become most accessible. It would, of course, guarantee physical ex-

aminations at whatever periods were deemed desirable for those of different ages and of various occupational hazards.

This system would correct the incongruous and unreasonable positions of doctors in the present chaotic condition of medical practice. Recent graduates would become members of the medical corps as soon as they were accepted as internes in a general hospital. As paid officers in the service, they would take more personal interest in their patients and more pride in the standard of their work; whereas now they are too prone to regard their patients' afflictions as impersonal medical problems and are too anxious to finish their appointments which mark the final stage in a too expensive and extended preparation for their careers as private practitioners. Besides, they could be supervised more closely and disciplined more efficaciously. Instead of serving one or two years during which they give less than they receive they would remain in the status of internes with pay for about five years, being worthy of their hire.

The aspirants for specialties would be trained only after thorough experience in general medicine. When fully trained they would be granted suitable degrees and would not, as are so many immature and untrained specialists of today, be forced to continue to devote, a part of their time to general practice in order to eke out a scant living. Being interested only in the financial aspect of general practice, these latter are not infrequently guilty of haste and carelessness, and also of abusing the confidence even of long trusting patients.

The older physicians in general would not be constrained to do things in which they had ceased to be interested and which they had done just as well earlier in their careers. Under individualistic medicine doctors are frequently compelled to attend to minor cases of illness or injury which do not warrant their particular attention. After any one as learned as a doctor of medicine has lanced one hundred or two hundred boils or

repaired an equal number of scalp wounds, he can muster up little enthusiasm for them. He is apt to be rather slack in his technique. And no wonder! At this stage in our civilization the metropolitan bank president would hardly be expected to operate the comptometer or to count out the pay roll for a customer's factory. The medical officers of higher ranks would also be relieved of emergency and night work so as better to perform their duties of supervision, consultation, teaching, and administration. To undertake delicate operations, in justice to their patients, surgeons should not allow their judgment and skill to be impaired by loss of sleep.

There are several other glaring evils of competitive medicine that would be abolished by systematic coöperation. The necessity for individual physicians to render personal service to their patients at all times of the day and night too often induces weariness and brain fag. Under competitive practice, however tired they may be, they are impelled to cater to their patients in order to retain their patients' good will. However fatigued, they must always be ready to solve the most baffling problems in diagnosis demanding keen perception and clear reasoning, or to undertake the most difficult operations, requiring calm courage and manual dexterity. The effects of fatigue can be demonstrated in the physiological laboratory. The direful results of fatigue upon the part of the overtaxed popular doctor have been brought home to many families bereft of dear ones or burdened with invalids.

Haste with its baneful consequences would also be discouraged by collective practice employing the economic principle of the division of labor. Dispatch inevitably gives way to hurry where, on account of the gregarious nature of man, the sick and the hurt flock in increasing numbers to successful practitioners who dare not refuse their services to any for fear of offending them, or who desire not to miss any fees. Overworked practitioners have been known to dispose of their patients at the rate

of one every six minutes; and yet the finger nail is more intricate than the most complicated machine. Hurry results, too, when the idolized busy physician, though jeopardizing lives and limbs, is constrained to make hay while the sun shines. For, competitory practice is so exacting physically, as well as mentally, that the earning power of successful physicians begins to decline at an age earlier than that of other professional men. It is in fact so strenuous that the mortality of the medical profession recruited from a picked class of persons vigorous enough to devote nearly half their lives to study and training is greater than that of the general population, including steeple jacks and aviators. The family physician conducts a one man business entailing continuous hours of duty with multifarious responsibilities as counselor not only in medicine, but often in law and religion, as bookkeeper and investor, chauffeur and mechanic, teacher and head of a family. Little wonder that he blunders tragically.

Carelessness upon which individualistic practice exercises no direct check would be curbed by state medicine. Today even reputable doctors make fatal errors through the negligence of examining their older, more familiar patients incompletely, because of assuming too much knowledge about them; for the human body is so complex that symptoms arising from an affection of one part may be referred to another part. More than one observant interne have remarked about the superiority of the treatment of the ward charity patients who are put through the routine hospital examinations, over that of the private room pay patients whose doctors assume that their familiarity with them renders the cost of such a thorough study unnecessary.

Carelessness is rife among a less reputable class of busy physicians who practice the art of medicine, the easier phase, in contrast to the science of medicine, the harder phase. They have no time or need to keep up to date, because their very success is assured by the foibles

of the benighted and the unintelligent. Indifferent to the cause of diseases, they dispense a separate pill for each of the complaints, however numerous. To serve is not their motto, but to exploit. Other doctors equally negligent are those loath to relinquish the care of patients to colleagues better qualified to treat them. Since it has been estimated by experienced drug salesmen calling upon the members of the medical profession that eighty per cent of the medical work is done by twenty per cent of the doctors, it is manifest that carelessness as well as fatigue and haste must do incalculable harm, and that there should be adopted a coöperative system with its guides and checks upon its members.

A need that private agencies have not supplied for the public, the public must provide for itself. Since the Bureau of Medicine and Surgery of the United States Navy, a truly efficacious organization, offers a practical model for the needed medical reformation, it is surely time to dispel the bogy of state medicine and to found this proposed system of government medicine.

TRAILING THE ROBIN HOODS OF MEDICINE[4]

When we get around to the organization of a real health service for the nation, if we ever do, we shall be forced, I think, to an agreement upon the following things as essential.

First, the virtual elimination of the private practice of medicine, with the substitution of a national health organization in which all doctors shall be servants of the state, with all or a basic part of their income guaranteed. We shall be forced to this if we apply intelligence to the health problem not as a socialistic theory, but as a social necessity. Here are some of the considerations that will force us to this conclusion.

Under the existing régime of the private practice of

[4] From article by Glenn Frank. *Century Magazine.* 102:953-60. October, 1921.

medicine we have no guaranty that doctors will be wisely and strategically located, no guaranty that every community in America will have access to the medical science and service that it must have if America is to keep at its physical maximum. To-day doctors locate for practice exactly as tailors locate for tailoring, in search of a privately profitable future, with the result that many communities are undersupplied, while other communities are oversupplied with doctors. In an intelligently organized world only one consideration would dictate the location of doctors, namely, the accurate supplying of medical counsel and service to every community in America, and to every man, women, and child in every community. Some day we shall zone the country for medical purposes, as we have zoned the country for our federal reserve banks.

Under the existing system of the private practice of medicine doctors have a "vested interest in ill health" instead of a vested interest in good health. I am not falling into the facile assumption that doctors habitually perform unnecessary operations and prolong sickness in order to run up a bill. I shall leave that libel to Bernard Shaw, and, stated flatly as he states it, it is a libel upon the most unselfish set of professional men in the world. But the fact remains that the existing system, in its ultimate outworking, does put a premium upon disease rather than upon health. In the main, doctors secure their income from curing sick folk, not from advising well folk how to keep well. The tendency toward retaining doctors as health-advisers is growing, but it is a tiny tendency that to-day affects the total health problem only slightly. It should be said, in passing, that no man in America recognizes more fully the wasteful insanity of making doctors healers of disease rather than protectors of health than does the doctor himself. But until we evolve a system under which doctors are not obliged to make their income from attending cases of sickness, our only hope of a healthier nation lies with the unselfish

doctor who will consciously reduce his income by foisting upon sick patients health advice that will tend to keep them from falling sick again. And, mark you, he must usually give this preventive advice as a side issue to medical attention, give it to a sick patient whose mind, at the moment is more upon his immediate plight than upon the future regulation of his habits. The doctors are not to blame. We are. Our national motto seems to be, Millions for pills, but not one cent for preventive advice.

Under the existing system of the private practice of medicine we have no assurance that every doctor will spend as much time as he should in preparation for practice, no assurance that after he begins practice he will keep constantly in touch with the latest results of research and experiment, no assurance that he will periodically refresh his knowledge and perfect his technic by attendance upon lectures and clinics. We are convicted of plain bankruptcy of political intelligence by our failure to make it possible for any and every student of medicine to spend as long a time as may be necessary in study and preparation for practice, regardless of his personal financial resources. It may be said that I overlook the fact that we have definite and required standards of preparation in our medical schools, that our licensing systems prevent men from entering the practice of medicine until they have undergone the required preparation. I have not overlooked that fact. My point is that the requirements of our medical schools are, even at this late date, conditioned and restricted by the economics of the situation, the amount of money that students can pay, the amount of money that can be wheedled from private pockets into endowment funds. In the final summing up of the case, the length of time required in preparation for the practice of medicine, the number and quality of men who serve upon medical faculties, the physical equipment of laboratories, and the like, are all, to a greater or less degree, determined not

by what the institution needs, but by what the institution can pay for. In a state based upon intelligence instead of upon expediency and drift, these things would be determined only by the health needs of the nation. However large the necessary funds, they would be supplied by taxation and not wait upon the whims of philanthropists.

Under the existing system of the private practice of medicine most doctors do not become rich men. Thousands upon thousands of doctors are not financially able to secure the latest information, week by week, from the great research laboratories. True, we have medical journals here and abroad, but they are, in the main, private properties run for private profit, or by societies which doctors join or not as they desire or can afford, and their content as well as the extent of the information they supply must be tested by the question, Will it pay its way? An intelligent state would see to it that every doctor in America received weekly bulletins that contained the latest and most authentic reports of the progress of medical science. Thousands upon thousands of doctors simply cannot afford to attend lectures and clinics periodically. Again, an intelligent state would see to it that every doctor in America was not only enabled, but required, thus to refresh his knowledge from time to time.

In short, if we faced the health problem scientifically, if we loosed ourseves from the dead hand of tradition, we should district or zone the nation, locate our health army of doctors solely upon the basis of the needs of each community, relieve the doctor of the necessity of depending upon sickness as a source of income, organize the medical profession upon basis of an intelligent division of labor, with the result that the people of every district or zone would have ready access not only to general practitioners, but to specialists, for diagnosis and treatment. This access to specialists would not depend, as it now does, upon whether the people of a given

community are within easy reach of a city. The personnel of the medical staff in each zone or district would be made up of the required specialists and general practitioners. These specialists would be required not only to diagnose and treat cases of sickness, but they would be required to collaborate with the general practitioner in the periodic physical examination of the families he served.

With such an organization in operation we could really launch a national war on disease, not only on the manifestations of disease, but on the causes of disease. Here, if anywhere, we could find that "moral equivalent of war" for which the race is searching. Gorgas trailing yellow fever to its endemic home entered upon as thrilling and as adventurous an undertaking as any conceivable military campaign. A national health army would face just as thrilling and colorful an undertaking in the United States—an undertaking that would absorb that fighting instinct which cynics like to say will make war an eternal practice of the race.

We have the raw materials of such an organization at hand. Thousands of doctors are now servants of the state or in semi-public work as municipal health officers, school physicians, factory and mine inspectors, and the like. But all this is uncoördinated and falls far short of its possibility. Let us have a national General Staff for Health, for purposes of general direction and leadership, with a healthy decentralization of administration in the regionalism before suggested. Let this general staff organize the war on disease and perfect the organization of the army of health advisors, working out a vast collaboration between the doctors and the architects, the engineers, the amusement-promoters, the teachers, the chemists, the cooks, the grocers, between the doctors and all the servants of society who directily affect the health of the nation. Let the program include a fundamental consideration of the three basic problems of food, housing, and work. Let the health army seriously undertake

the prevention of disease, as the present array of unorganized private practitioners cannot save intermittently and piecemeal. Let every family in America secure its doctor's services by the year instead of by the case or by the visit. Let payments be made monthly, quarterly, semiannually, or in advance. For this payment, which might be required as a form of taxation, let the doctor be obligated to give every member of the family a physical examination at least twice a year, to make at least a semiannual examination of the house and grounds, advising on matters of ventilation, sanitation, food, clothing, and the like, to attend to all cases requiring services of a surgeon or a specialist.

Such a system would, as many doctors have pointed out, make possible many desirable things now prevented by the present system. Families would call the doctor at the first hint of sickness. No money consideration would enter. The doctor would have the advantage of early attention to the trouble. The doctor could call as often as necessary. No one could accuse him of fee-hunting. He could stick by the case as long as necessary. This system of yearly service would, many doctors believe, mean a larger average income for doctors and a general saving of the people.

THE MEDICAL AND ALLIED PROFESSIONS AS A STATE SERVICE[5]

There is no valid, other than a historical, reason why the scientific cure of disease should not be a state service as much as the scientific prevention of disease. The Indian Medical Service affords us an example of a state-managed medical service; it shows us how such an organization might be so vastly extended as to become imperial. Promotions, disability pensions, retiring pensions, etc., would be arranged for as in the Civil Service.

[5] From article by D. Fraser Harris, M.D., Professor of Physiology, Dalhouse University, Halifax, N. S. *Scientific Monthly.* 11:235-45. September, 1920.

The state would, therefore, also logically take care of the problem of research in medicine, and, directing it, coordinate the isolated efforts made in it in the manner most beneficial to the public weal. In the United States, private enterprise has endowed medical research in a truly magnificent manner. Private endowments could still be given for medical research within the British Empire, but it would be well if the directing of medical research were made a responsibility of the state. Much of it is even now, as for instance, the splendid work on plague done in India, and the work on cancer in London. The medical researcher is a medical man no less than the general practitioner; he is only more specialized; he should equally be a servant of the state.

In an article by Colonel J. T. K. Maurice, C.M.G., entitled "A Vision of State Medical Science," which was published in *The Hospital* for November 9 and 16, 1918, the matter is put thus:

> Let us say in sickness the best advice and treatment is to be placed within the reach of every man, woman and child of the community . . . thoroughly efficient measures to ensure the good health of the community are to be devised and properly carried out. . . Surgical and medical knowledge have stridden forwards so rapidly in the last few decades that the means of diagnosis and treatment to the hands of the medical profession are far more elaborate, far more efficacious and far more costly than they were heretofore. The guesswork of the old clinical diagnosis can be supplemented by X-rays, chemical tests, sera diagnoses and so forth, and an accuracy, a certainty, attained that was formerly impossible. . . These elaborate processes are expensive, many require special buildings, costly apparatus, and men of long experience and special skill to apply them; and so under present circumstances they can not always be brought to the service of the sick. . . Sera and vaccines, new powerful drugs, anesthetics, and antiseptic surgery, have brought about a wonderful change. But treatment by these means is an expensive matter, and entails the employment of highly skilled nurses . . . so the wages of nurses have risen and rightly. . . The total result of all these changes is that the expense of making an accurate and fully confirmed diagnosis and of giving thoroughly sound treatment and nursing is so high that it is unattainable to most of the population except by charity. It could, however, be obtained by cooperation and mutual assurance, either by voluntary association or by submission to the necessary taxation.

Either is better than the pauperization that comes of charity. The ideal is a healthy race, each man paying for himself or paying his share of the cost of maintaining the common health.

Sanitary science in all its wide ramifications has not yet come into its own. . . In some large towns a good deal is done to preserve health by preventing diseases. But the important step of thoroughly educating the mass of population has not yet been taken. All must learn that a healthy race implies parents without inheritable defects, strong and healthy in body and mind by gift of birth, implies restraint of the passions, avoidable of venereal disease, proper selection of foods, exercise in fresh air, avoidance of overcrowding, good ventilation of houses, healthy occupation, healthy amusements, and happy occupation of leisure instead of unwholesome pleasure. One of the first needs of health is to learn wisely to use leisure. All this must be taught. A state medical service should be an educating service. If a state medical service were formed, its functions should be executive and advisory. It should carry out measures to prevent disease, but the measures would emanate from legislative bodies. It should advise parliament, county councils, corporations and other public bodies. It should suggest legislation. It should treat the sick. It should educate the community in the ways of healthy living, and it should administer itself.

This state medical service is something more than merely organizing the medical profession as it exists at the present moment; it is nothing less than the creation of a state service for the explicit purpose of maintaining the highest health of the highest number of the citizens of our empire, and therefore systematically preventing the outbreak of diseases amongst them. This new service would conserve the health of all our social groups; the navy, army, the merchant marine, civil servants, inmates of prisons, penitentiaries and asylums for the insane, boys in reformatories, defective children, the blind and deaf and dumb, immigrants and all foundlings. This state service would so supervise the health of school children that all our present amateur efforts towards child-welfare would become superfluous. It would take charge of all hospitals, general, surgical, maternity, for venereal diseases, for cancer and incurable diseases, and, of course, of all sanatoria, for all institutions would then belong to the state. The service would supervise the noble nursing profession in all its activities. It would inves-

tigate all problems coming under public sanitation—adulteration of food, the storing, cleansing and distribution of water, inspection of ventilation, quarantine, prophylactic inoculation, and everything else included under "state medicine" in the older, more restricted acceptation of that term. It would supervise all specialisms and techniques, including dental surgery, orthodiascopy and the therapeutic use of all forms of energy. Naturally, the compilation of vital statistics would fall under the province of the service. Finally, it would not only organize, direct and reward research, but also organize direct and reward all forms of teaching required in the medical profession; for by the time of which I am speaking, the universities, like the hospitals and laboratories, would have become state institutions. There would not only be no private hospitals, there would be no private schools of the cause and treatment of rheumatoid arthritis and other medicine whatsoever. Research into such large problems as widespread diseases responsible for a large measure of national inefficiency and suffering, could at last become a national affair and be investigated on an adequate scale.

THE PAY CLINIC[6]

The Pay Clinic of the Cornell University Medical College in New York is a particularly interesting experiment in medical practice and demonstrates admirably the possibility of providing adequate care for people of moderate circumstances. It offers its service only to patients able to pay the prescribed fee: others are referred elsewhere for treatment. In determining which patients lie within its scope, it takes into account the size of the family as well as the income and the type of disease from which the patient suffers. For it is conceded that conditions likely to require long-continued

[6] From article "What Price Doctors?" by Louis I. Dublin, M.D. *Harper's Magazine.* 155:767-76. November, 1927.

treatment, or the use of elaborate equipment and costly laboratory facilities should be included, even if the family income would ordinarily be large enough to pay for private care. For the most part, patients belong to families having an income of about $2,400 a year. The clinic was opened on November 1, 1921, and on that day, over 1,000 persons applied for treatment. Many were in line for hours awaiting their turn. During its first six years, about 115,000 patients were registered. Together with the old patients on the books, about 21,000 people are treated each year and about 475 patients now come to the clinic each day. Over 130,000 visits were paid last year and the attendance is steadily growing.

This pay clinic at Cornell University replaces a charity clinic which was formerly considered a necessary part of the teaching equipment. The free clinic was operated at a considerable deficit. At the end of the second year after installing the new plan, the deficit of the clinic was reduced a half, and during the last few years it has been entirely wiped out. The clinic is now said to be self-sustaining. Patients are charged a flat fee of $1.50 per visit, but pay supplementary fees (at cost) for x-ray plates, for laboratory tests, appliances, eye-glasses, medicines, and other special items. In the year ending June 30, 1927, operating costs including depreciation on equipment amounted to $314,000, or an average of about $2.39 per clinic visit. As we have said, the charges for this service covered the cost, but the average amount paid by patients, including the extras, varied considerably according to the type of service required. In some departments, the average cost per clinic visit exceeds $5, whereas in others the cost was only $1.60. At all events, patients are receiving excellent service for about a third of what they would have to pay to the same physicians at their private offices.

All who know the work of this clinic are agreed that the standard of service is of a high order. This is further

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indicated by the enthusiastic response the clinic has received from its patients. The average number of visits per case is now close to five, a higher number than is usually paid at other clinics. Patients recommend the service to their friends, and this is largely the source of the new clientele. Physicians likewise refer many of their patients to the clinic. Thirty-five hundred doctors of the Metropolitan area have sent more than twelve thousand of their private patients to the clinic for diagnosis and consultation, and this type of service for private physicians is constantly increasing. The Cornell Clinic has established itself as an indispensable part of the medical equipment of the city. Its demonstrated efficiency in caring for cases which ordinarily would be difficult and expensive to treat will undoubtedly have a very large effect in further extensions of similar service the country over.

A similar method of supplying effective and economical medical service is the development of student health work in American secondary schools, colleges, and universities. Many educational institutions are located in small towns where private medical facilities are inadequate to care for the large number of students. The school authorities have, therefore, found it necessary to provide facilities of their own, using largely the excellent personnel and medical equipment of their own medical faculties. Such service is now widely available; perhaps the most interesting examples being found in the Universities of California, Michigan, and Minnesota, each of which cares for about ten thousand students.

In these institutions, the service is all-inclusive. The incoming students are carefully examined and receive advice as to their physical condition, as to what exercises to take, and how they may keep well. When a student is sick, he is encouraged to come to the clinic for the examination and treatment of minor affections. If the ailment is serious, or if it be a source of danger to others, the case is at once hospitalized and treated for a sufficient

length of time by the most approved methods. There can be little doubt that the service is of the best type and that the students are kept in excellent physical condition.

What interests us particularly in these demonstrations is the very low cost of the service. Dr. Sundwall, describing his work at Ann Arbor, says that each student is taxed six dollars a year for health service and that this amount is adequate to cover medical and nursing expenses together with the cost of the equipment. This small sum is also the amount of the annual fee per student at the University of Minnesota where an excellent service is rendered. The fee will be increased to nine dollars with the new semester. At the University of California, the actual cost of the service is more nearly $12.30 a year.

These college health organizations prove that a reasonably complete medical service can be rendered at an extraordinarily low cost. The small fees in the above universities cover virtually everything including drugs, laboratory tests, examinations, and hospital care. At California, the only additional charge is apparently a low and uniform fee for surgical operations. At Minnesota, small additions are charged for dentistry and a few other items. At Ann Arbor, the average cost of a clinic visit is only eighty-five cents; at California, it is only a little more. Hospital care costs the college about $2.50 a day.

The movement for good medical service is spreading to students at most American colleges. More and more colleges are supplying this service for students at low cost. In a few institutions the faculty members are receiving similar care, and in a few others a movement is on foot to make the service available to the families of the faculty. These experiments will have a definite bearing on the problem of the cost of medical service. Their appeal is not only because of low costs. The service rendered is of a high order and at the same time democratic, eliminating the distinctions which ordinarily follow differences in economic status. The poor and the rich pay the same fees and receive identical treatment.

Nevertheless, I believe that group medicine will have no adverse effect on the finances of the medical profession. It will not result in any lessened demand for the doctor's services but should rather increase the amount of his work. Thousands of people who now find it difficult to consult physicians because of the expense will find in the pay-clinic a ready means for doing so. The propaganda for periodic health examinations will work in the same direction; for the clinic is especially adapted to render this type of service. It is to be expected that under such extension of group-medicine doctors will devote much of their time to the clinic but they will be paid for their service. There will always be a large number of people, however, who will insist on the old-time intimate relationship existing between doctor and patient. Patients confined to bed will also require individual care. The private practice of medicine, even if somewhat curtailed, will always remain indispensable. But the time devoted to private office practice should, under new conditions, be paid for on a more lucrative basis than at present. It will then be pertinent to determine what a fair charge for this highly individual and private service is. A scientific determination of the charges will involve evaluation of such training, the cost of his equipment and overhead, the time that he has available for private patients, having always in mind the standard of living which the community expects him to maintain, and a margin sufficient to provide for reasonable leisure and the protection of his old age. There is altogether too much guesswork at the present time about all these factors. Such an evaluation conducted along scientific lines would be a first-class contribution to the solution of the economic problem of medical practice.

BRIEF EXCERPTS

As a consequence of these experiences of the Insurance Act and its administrators, the British Medical

Association is stronger, more representative and more capable of defending the interests of its members than ever before.—*Alfred Cox, Medical Secretary of the British Medical Association, in the Journal of the American Medical Association. My.* '21.

What about the cost of this system of socialized medicine which I am advocating? Can the state shoulder the burden? Well, the state is paying much more dearly now. Figure it all up in dollars and health. Add up the millions spent in quackery, on tons of health-undermining patent medicines, the hosts of victims of preventable diseases or of diseases curable if nipped in the bud by timely and scientific diagnosis and treatment. Count up the cost of reduplication and waste in private practice, in charity drives and charity management.—*Joseph Krimsky. Nation. O.* 20, '26. *p.* 399-400.

Medicine is rapidly becoming a function of the state. It will mean state control and state support for public health, for medical licensure, for medical education, for medical research and to an increasing extent the medical care of the helpless. . . and when we have educated the people we will have no difficulty in securing the necessary laws, machinery and funds to make medicine in the best sense a great function of the state. . . If the profession in this country is far sighted it will recognize these coming events and direct them wisely.—*Arthur Dean Bevan, in address before the Council of Medical Education of the American Medical Association in* 1914. *p.* 821-3.

If group organization fails the alternative is state medicine. There are ample signs of this alternative. Step by step free medicine has been encroaching upon medical practice. Hospitals, dispensaries, clinics, school hygiene, industrial medicine and public health work are all encroaching upon the field of the physician. A smaller and smaller proportion of the aggregate of medical service is

being given on the old basis. Probably half the medical care in the leading cities of this country is now provided outside of the private practice of physicians.—*John A. Lapp, in "Health Insurance as a Means of Providing Medical Care." Conference of Social Work. Proceedings.* 1919. *p.* 194.

I would differ with the last speaker, in that he stated that often free service was a pauperization of the public. As far as I can see, it is no more pauperizing than the classes and activities carried out by the boards of education. They are giving types of service, cooking classes, music classes and such, which some might just as readily say should be paid for by the individual family. Now our health department will only give in so far as the public demands them to give. If they are doing too much I think the public will soon see that their activities are circumscribed.—*C. V. Craster, M.D. before the Forum Session of the American Public Health Association at St. Louis, Mo. O.* 21, '25.

There are more than a million persons engaged in curing and preventing disease. . . and more than five billions invested in hospitals and other equipment. Nevertheless, a large group of persons are not receiving needed medical treatments at costs within their means. Complaints of high charges are becoming frequent and I fear that some of them are justified. The cause of the difficulty, often, is the large number of separate bills which must be paid, not the amount of the physician's charge.

Physicians, as a group, are not earning adequate incomes; and for many, hospitals and other facilities for scientific work are lacking. Nurses and dentists too, fail to receive satisfactory returns for their labors. Apparently it is the present system that is at fault.—*Dr. Ray Lyman Wilbur in press bulletin issued by the Committee on the Costs of Medical Care.*

Modern medicine, and particularly modern preventive medicine is fundamentally the interpretation and application of modern medical research. The discovery of the germ theory of disease has changed the picture almost completely. If the full value of this discovery is to be gained, knowledge of it must be universal. Education in this field must begin with the child; it must be made a part of our public school education. It must be given to the adult. It must find its practical application in the type of health centers such as you have developed in this community. Modern medicine, viewed from this point of view, is a cooperative undertaking. It involves a definite understanding between the physician, the parent, the child, the teacher, the public health administrator, and the legislator. Only through such concerted, cooperative effort, involving everyone in the community, can we hope to reach the goal which preventive medicine has set for us—the reduction of disease to its minimum and the prolongation of life for one and all to the full biological limit.—*Lee K. Frankel, Ph.D. in address before West End Health Center, Boston, Mass., September* 15, 1930.

Latvia has a very efficient and satisfactory system of state medicine which does not break down the doctor's morale or conscientious skill as American doctors declare it would demoralize theirs. This system of medical aid is extended to all workers; the dues amount to eight per cent of the worker's wage—four per cent paid by the employer, two per cent by the government, and two per cent by the worker. Contracts are made with physicians, surgeons, and dentists for treatment at standard rates; and eight hundred of the country's nine hundred and eighty-eight doctors work on such contracts—an arrangement considered nefarious by the American Medical Association. The customary fees for doctors are from $.77 to $1.94 in Latvia, but workers pay from $.19 to $.57 under the state system. yet the doctors earn good livings. Those desiring special doctors or luxury service

get it at correspondingly higher rates. The system includes all varieties of medical, dental, and pharmaceutical work. In 1927 the receipts of the system were $2,207,863 and the expenditures $2,144,959. Many other small and "backward" countries have such systems, which, it appears, the wealthy United States of America cannot afford.—*T. Swan Harding. Forum. Je. '29. p.* 349.

When a health officer looks over the field and sees the great need for corrections of defects of the eye, nose, throat and teeth, he is convinced that in this field alone is enough work to keep the time of the practitioner of medicine and dentistry busy for years to come. Many physicians sit in their offices waiting for patients to come to them, when all about them is work to do. The so-called *medical ethics* have said that they must not advertise. It never occurs to them that perhaps it is their duty to so educate their community, in a proper and ethical manner, to the fact that for their own welfare they should come to his office at least once a year for a thorough physical examination. The family fails to remember that the physician has had the good fortune to have had the benefit of a scientific medical education, and that he is one in a thousand, and that the other nine hundred and ninety-nine are entitled to his advice and counsel; and that by giving freely of this advice and counsel through the organization of health societies, through speaking from the public platform before civic organizations of the butcher, the baker and candlestick maker he can call their attention to the fact that their body is the one machine in their possession that cannot be replaced with a new one. It is not only his duty to so carry this message to them, but it is his duty to insist upon their going either to his office or some other medical man's office for an audit of their physical condition.—*John Dill Robertson, M.D. American Journal of Public Health. Ja. '23. p.* 3.

NEGATIVE DISCUSSION

SOCIALIZED MEDICINE[1]

The cost of medical care has increased greatly and is giving concern to sociologists and economists. For some time the statement has been made that only two groups of persons can afford to be ill, the wealthy and the very poor. The former are able to pay for what they get and the latter get a rather good type of service without charge.

The group that gives the greatest concern to students of the situation is the middle class. This group has been the victim of exploitation since the earliest times. It exists in one-room kitchenettes in the cities and must perforce go to the hospital in times of sickness. In the country and in the villages it is far removed from the available hospitals and pays mileage charges in addition to medical fees for medical attention. Because of its transient character it has fallen out of touch with the old-time family physician. This group, therefore, usually provides the primary source of revenue for medical quacks of every sort. The member of the middle class is likely to attempt to save the cost of a visit to a physician by purchasing a patent medicine widely advertised in the press or by asking the corner druggist to prescribe. Middle-class workers are likely to join fraternal orders which maintain incompetent lodge doctors. Sometimes they work in large industrial plants or factories, where a certain sum is taken from their wages each week to pay for treatment in the factory hospital or for a visit from

[1] By Morris Fishbein, M.D. Editor of the Journal of the American Medical Association. *Nation.* 126:484-6. April 25, 1928.

the factory doctor in time of sickness. As a result numerous leaders in the public-health field have urged the establishment of compulsory health insurance or other health schemes to provide funds for the care of the middle class.

Some economists have insisted on a state system of medicine which will provide health care in much the same manner as the state cares for education. Gerald Morgan, for instance, has insisted that there must be a radical change which will emancipate health in some way from the fetters of the existing acquisitive economic system and provide free periodic physical examination regardless of known ailments and some financial provision for the families of those needing help in time of illness.

Professor C. E. A. Winslow, when president of the American Public Health Association, said that the purely individualistic practice of medicine, as it has existed in the past, must be increasingly supplemented by a form or forms of organized medicine which will offer to the individual modern scientific medical care including laboratory and specialized consultation service on an economic basis which will facilitate its application to the prevention of incipient disease—probably on some basis which involves payment of the physician through a common fund for the supervision of the health of an individual rather than for the treatment of a specific ailment. . .

The American medical profession has looked with increasing concern at attempts to establish similar state systems in this country. For instance, the Committee on Public Policy of Ohio State Medical Association, at its last annual meeting, presented a resolution which was adopted by that State organization, objecting to every possible encroachment of the state on private medical practice. They objected to the extension of free clinics, to the growth of health-insurance ideas, to the widespread propaganda for nationalization of property and socialization of personal service, to the increase in health charity for those able to pay, to personal health service without charge in educational institutions, and to every other

tendency of governmental agencies and departments, to interfere with the relationship between patients and their individual physicians.

The mechanization of medicine is an evil recognized by every physician as a menace to sound medical practice. Come what may, the intimate personal relationship of physician and patient is essential to complete relief of the patient's ills. Even the periodical physical examination is unsatisfactory when applied on an impersonal basis. True, it may detect the scientific evidence of incipient physical disease, but it does not get at the personality of the patient in the manner that formerly resulted from the relationship between the general practitioner and his patient. Even the best social-service technique may fail to find the human being that the old-time physician used to know in each of his patients. A single point in the life history of the ailing individual may explain the major part of his symptoms and his distress. Not infrequently that point is carefully concealed from everyone except the personal physician in whom the patient has the same confidence that members of some churches have in their priests.

The evils of socialized practice, indeed of any impersonal method of medical practice, are generally recognized. They involve inadequate compensation for physicians: the average salaries of doctors in state or commercial organizations rendering such service are between $3,000 to $4,000 a year, notwithstanding the fact that an adequate medical education may cost the doctor approximately $20,000 to $25,000. The standards of medical practice are lowered because the tendency of the contract doctor is to see as many patients as possible. Patients are moved along without adequate attention. In some parts of the country doctors engaged in contract practice attempt to see eighty or ninety patients each day. The physician falls into the deadly routine of contract work, initiative is lost, and advancement is dependent on the individual's ability to pull wires.

SAN FRANCISCO TUBERCULOSIS ASSOCIATION

Only too often industrial medicine has become an instrument for fighting compensation claims. The salaried medical services of department stores and of factories are so impersonal that many employees prefer, even though assessed for the provision of medical care, to seek out a personal physician in time of stress. Why should not a democracy attempt to insure the worker a salary or wage adequate to provide for medical treatment and ask the medical profession to organize itself for the provision of such treatment, rather than pauperize the middle class by degrading the medical profession?

More and more the advances in modern medicine reveal the essential differences between individuals that make routine methods of diagnosis and treatment impossible. More and more physicians are beginning to recognize the influence of the mind in disease and in the treatment of disease, a factor invariably lost in mechanized practice. State medicine might provide a standardized diagnosis and treatment for a standardized citizen; but it means the death of individualism, of humanitarianism, and of scientific practice. Until we become a nation of robots with interlocking, replaceable, and standardized parts, there will be little need for completely standardized doctors.

THE MEDICAL PROFESSION AND THE PATERNALISTIC TENDENCIES OF THE TIMES[2]

Paternalism in Medicine

In order to comprehend the paternalistic attitude of government or of society toward matters pertaining to health and general physical and mental well being, it is not necessary to trace the history of medicine from the

[2] By William Gerry Morgan, M.D. From his Presidential Address before the American Medical Association at the Eighty-Frst Annual Session, Detroit, June 24, 1930. *Journal of the American Medical Association.* 94: 2035-42. June 28, 1930.

time of the migratory clan, with its tabus and its incantations. As all know, it was long after our progenitors settled down with an established form of government that the practice of medicine developed into anything beyond the incantation, voodoo, superstitious, religio-medical stage. But the individualism which developed as the human race became organized into a more and more highly complex system of life finally began to manifest itself in a new interpretation of the idea that in union there is strength; and with this, as physicians, we are concerned.

The *laissez faire* state, by its hands-off policy, had made it possible for certain industrial groups to exploit members of other less favored groups, and thus there came into being the two great divisions of society commonly known, then as now, as capital on the one hand, and labor on the other. To whatever extent the oppressive methods of the former weighed down the latter, the *laissez faire* state maintained its policy of let alone. As the outcome of this condition of affairs the oppressed class began to organize for protection, for mutual help in times of sickness, sorrow and death, and in other ways to be of assistance to its members. Trade unionism then appeared, following the earlier master and journeyman guilds, with their various mutual aid organizations. This manifestation may be called unionized individualism—a sort of group paternalism born of the pressure of circumstance.

After a while the employer class waked up to the realization that a laboring class distraught by sickness and its concomitant poverty was not the best economic asset, and with this realization, plus whatever higher motives may be fairly attributed to them, they began to evolve to foster the welfare and relieve the sickness and distress of the workers and their families.

Thus there gradually developed, on the one hand, the mutual aid societies representing the various trades, and, on the other, what may be called organized philanthropy

among employers, with resultant hospitals, homes, funds and other facilities for guarding the health of the masses and preventing or ameliorating the financial distress of the sick and their families.

The mutual aid movement, said to have been inaugurated in Great Britain, "the classic land of friendly societies," soon spread to other countries and began to assume new aspects.

The *laissez faire* state, observing these trends toward group or trade mutual aid organization, on the one hand, and employer philanthropic organization for the benefit of the employed, on the other, abandoned its hands-off attitude and began to assert its dormant paternalism by not only encouraging the organization of these non-governmental mutual aid and philanthropic movements but, in some instances, going a step further in enacting legislation by which such movements were given governmental recognition, a certain oversight, and, in some instances, financial assistance from public funds.

It is not difficult to understand that the state, sooner or later, would go beyond the phase of passive oversight in the way of authorizing the establishment of these mutual aid organizations and of regulating the relations between those who conducted them and those who were the beneficiaries, in accordance with laws enacted for the purpose. Thus we find the more active intervention of the state taking the form of either compulsory or voluntary sickness or health insurance.

This matter of sickness or health insurance has not, as yet, played so conspicuous a part with respect to the medical profession in this country as it has in others, notably Germany and Great Britain. But here, as in other matters, it behooves us "to see the whole" and to "look to the end."

Voluntary Sickness Insurance

With the voluntary system of sickness insurance, sometimes called health insurance, the medical profession does not find so much fault, though recognizing its

paternalistic aspects. There are numerous analogous illustrations of what might be called quasipaternalism, since the element of compulsion is not present. Legislation of this kind, according to the International Labor Bureau [2] of the League of Nations has been adopted in Italy (1886), Sweden (1891), Denmark, (1892), Belgium (1894), Finland (1897), France, (1898), Spain (1908) and Switzerland (1911). Thus, we are told, the mutual aid movement, assisted both materially and morally, developed rapidly, until thousands of societies have been formed, having in some countries hundreds of thousands, and in others millions, of members. By 1927 it had spread to South America, Australia, New Zealand and Canada.

The nearest approach to this plan of insurance which we have in this country is the Federal Workman's Compensation Act, and the industrial insurance acts of different states.

While all this is patently paternalistic, and not in keeping with the highest type of economic life, it does not bring the insured who fall ill or the physicians who treat them, under the strict category of state medicine. The next phase, compulsory sickness insurance, is of vital interest and increasing importance for the reason that it is plainly a manifestation of the paternalism which has come to be known as state medicine.

Compulsory Sickness Insurance

Quite naturally, the superpaternalistic League of Nations, through its International Labor Bureau, approves of compulsory insurance, as learned from its 1927 report: [3]

In spite of its valuable achievements, the voluntary insurance movement has been found insufficient, and it has become clear that the way to secure general and effective protection against the risk is by making insurance compulsory. The modern state,

[3] International Labor Office. *Compulsory Sickness Insurance*: Comparative Analysis of National Laws and Statistics, Series M, number 6, Geneva, 1927; *Voluntary Sickness Insurance*: Collection of National Studies (Laws and Statistics), Series M, number 7.

as guardian of public health and national prosperity, considers it both a right and a duty to impose compulsion. Even the devotees of individualism admit that in a well organized community a person should not be free to indulge in improvidence which leads to his becoming a charge on rates, and that insurance is a social duty the performance of which the state may, in the general interest, enforce.

How does compulsory insurance affect the medical profession? it may be asked. There are two notable answers to the question; namely, Germany and Great Britain.

Germany was the first country to establish this kind of insurance, and, according to the International Labor Bureau of the League of Nations, this was done, in 1883, without any lengthy experiments with the voluntary method. Austria followed in 1888, Hungary in 1891, Luxemburg in 1901, Norway in 1909, Serbia in 1910, Great Britain in 1911, Roumania and Russia in 1912, Bulgaria in 1918, Czechoslovakia and Portugal in 1919, Poland in 1920, Japan and Greece in 1923, Chile in 1924, and Lithuania in 1925. France is the most recent addition to the list of countries to adopt this kind of paternalistic legislation. The system has been inaugurated in these countries with varying motives and with different details as to the actual working of the scheme.

In Germany[4] "this creation of Bismarck's" was keenly opposed at first by the German working class, on which the compulsion fell. We are told by the International Labor Bureau that it was doubtless inspired by a political motive, the purpose being to attach the workers to the state as the defenders of the capitalist system. It aimed at rendering less of a menace the numerous relief funds connected with trade unions, which might have been dangerous weapons in a class struggle. Bismarck's plan of making secure the means of subsistence of the working class, it is said, raised a solid barrier against socialist propaganda. It is not necessary here to go into the details

[4]. Dawson, W. H. *Social Insurance in Germany,* 1883-1911: *Its History, Operation, Results and a Comparison with the National Insurance Act,* 1911, New York, C. Scribner's Sons. 1912. Hooper, E. *The German State Insurance System for Providing Invalid and Old Age Pensions,* London. E. Wilson. 1908.

of the system thus inaugurated and its extension from one class of workers to another until, by 1927, it included all of the so-called laboring class whose annual income, after deducting family allowances, equaled 3,600 marks.

The medical benefit under this form of insurance is due from the beginning of the illness, without any waiting period, and it expires, at the latest, at the end of the twenty-sixth week following the beginning of the illness. It must be in kind; in other words, the benefit is medical service and not money repaid to the insured in lieu of such service. The state is bound to place the services of a physician at the disposal of the insured. This detail is arranged by agreement with medical associations or with individual physicians. Medical benefit includes dental treatment, the services of specialists when needed, mechanical treatment, roentgen therapy, diathermy, and other special forms of treatment, and traveling expenses necessitated by recourse to the physician. The sick person bears no part of the expenses of treatment. Drugs, spectacles, bandages and all necessary accessories to treatment are supplied without cost. The committee by which the insurance fund is administered is free to decide whether or not the patient shall be sent to a hospital. Once the insured gives his consent to treatment, it cannot be revoked; he is bound by his consent so long as it is deemed necessary for him to receive hospital treatment.

Any physician who wishes to become a part of this great paternalistic scheme by securing the right to treat the insured sick must apply to be included in the register of insurance physicians. In the district of each insurance office there must be one physician to 1,350 insured persons, or to every thousand of insured persons if the family of the insured is entitled to medical benefits. It appears that the much debated question of the insured sick person's right to the selection of the medical practitioner has not been satisfactorily settled in Germany.

The International Labor Bureau of the League of Nations has now put its stamp of approval on this scheme in the following words:

After forty years of experiment, uninterrupted effort, and success in all parts of the world, the cause of the compulsory principle seems now to be finally gained, and compulsory sickness insurance appears likely to occupy an increasingly important place in the social legislation of every country.

The workers, as I have said, at first opposed the plan. The population of Germany in 1920 was 59,178,185; in 1925, 62,348,782. The ratio of persons coming under compulsory insurance to those voluntarily insured is given as follows: 1914, 14 to 1; 1919-1921, 9 to 1; 1922, 10 to 1; 1923, 9 to 1; 1924, 10 to 1, and 1925, 10 to 1. The relation of the insured to the total population (number of insured per hundred inhabitants) varied from 20, in 1915, to 32, in 1925.

It is not a matter to be wondered at that, since the establishment of the sickness insurance in Germany, physicians and the insurance societies have waged continual battles. Finally, it seems, under the leadership of the national medical association, the physicians for a time refused to provide medical services for the hundreds of thousands of insured and their families. Physicians who lend themselves to such a scheme, having to see from ninety to a hundred patients a day, and having to make the required written records of each, cannot possibly do justice to any one except the insurance company—that they must do if they expect to be retained on the list. The physician cannot possibly have time and composure for medical research. In fact, as it has been expressed, "he has no more pride of occupation than the man who spends each day turning the same bolt on the same axle in the assembling of a cheap motor car." Each day he must turn in to the insurance company his quota of reports. The close personal relationship between physician and patient and patient's family cannot exist under such circumstances. It seems incredible to one of independent spirit that either the workers or the physicians could be satisfied with such a scheme.

In Great Britain,[5] the other notable example of this form of paternalism, similar conditions exist. A glance through the *British Medical Journal,* the *Lancet* and other British medical journals issued before and since the insurance act was passed reveals the equivalent of many volumes of criticism and protest against this form of insurance legislation, which, it has been said, was forced by "blatant propagandists" on the country over the concerted opposition of the medical profession, and of dissatisfaction with its operation, even to the present moment. Once the legislation was enacted there were two different currents of opinion with regard to the policy that the medical profession should adopt concerning its part in the program. The first of these opinions held that the physicians should refuse "to undertake any duties which the bill proposes to assign to them." In other words, the medical profession was exhorted to play an absolute hands-off, noncooperative role. The other opinion centered around the enforcement, by the British Medical Association, of six cardinal principles, commonly known as the "six points," to be included in the legislation; otherwise, no medical attendance and treatment of insured persons was to be engaged in by the profession.

Among the six points on which the association insisted were that the patient should have free choice of the physician; that medical remuneration should be what the profession considered adequate, and that there should be adequate medical representation among the insurance commissions. The fact that the act was called "the great betrayal" indicates how incompletely the demands were met. Letters were written and speeches made to decry it, on behalf of the public as well as the profession. Sir James Barr, writing against the act from the point of view of the public, upbraided members of the British Medical Association who did not attend their respective

[5] Dixon, Montague. "Remuneration of Medical Practitioners Under the Insurance Act." British Medical Journal. (supp.) 2:18. July 13, 1929. Woodmark, A. S. "National Health Insurance Seen by Consultant Physician." Ibid. 1:237-40. June 9, 1928.

meetings, and who waked up only when they found their own craft in danger. (Our own members may well heed the warning implied in these words.) The act, the writer of this protest said, "is a long step in the downward path towards socialism. It will tend to destroy individual effort, and increase the spirit of dependency which is ever found in degenerate races. This spoon-fed race will look more and more to a paternal government to feed and clothe it, and not require it to work more than a few hours daily. They will be further encouraged to multiply their breed at the expense of the healthy and intellectual members of the community." (Just how far the operation of this legislation is responsible for the millions of unemployed in Great Britain today is not for us to say.) . . .

Since the passage of this act in 1911, more than 400 regulations, order and circulars have been issued concerning it, none of which have appeased the dissatisfaction of the British medical profession, if we may judge from the printed criticisms which continue to appear in the medical press. Despite all this dissatisfaction, however, there were in England, Scotland and Wales, in 1927, 38,486 physicians on the official medical lists, each entitled to treat insured persons!

From the panel physician's point of view it seems that there must be ample cause for complaint. Each panel physician is supposed to attend a maximum of about a thousand patients. Should one of these patients have a fancied or real cause for dissatisfaction with the physician's service, a complaint may be lodged against him with the Ministry of Health. A committee is assembled to hold an inquiry. The object of the committee, we understand, is to reach findings of fact; in other words, to render a verdict equivalent to "guilty or "not guilty." Should the verdict be "guilty," the Ministry of Health assesses the measure of blame and fixes the punishment. The committee, the members of which see and hear the accused, cannot do more than make recommendations.

Commenting on this, in an editorial under the caption, "The Panel Doctor's Grievance," the *Lancet* says that up to this point the machinery has operated without complaint, while from this point onward its working may be open to grave criticism. Should an appeal be taken from the decision, "the officers of the Ministry sit *in camera*, rehearing the case without either seeing the witnesses or calling upon the defendant, and they may announce an adverse decision. The committee's recommendations may be set aside," should it be favorable to the accused, "and a smart fine inflicted, while, for all the victim knows to the contrary, the grounds for this new decision may be the merest caprice, unrelated either to the original charge or to the evidence previously given. It is small wonder," continues the editorial, "that panel doctors are disquieted by such incidents or that other practitioners display reluctance to expose themselves to the risk of such treatment."

The wonder to us is that any member of the medical profession anywhere would become part and parcel of such a scheme. And yet, within our own ranks there are men in high places who are engaged in propaganda to bring about some such system of practice in this country. We have enough of it already in so-called contract practice, in lumber camps, "sweatshops," and various commercial and industrial institutions; do we want the paternalistic hand of the government to reach out and take hold of medical practice in any such fashion as that started by Germany and followed by so many other countries? Do we want any form of state medicine, within the definition laid down by this association?

The Public Health Movement

Sir William Smith, from whom I quoted in the beginning, speaking for his own country, said: "The science of preventive medicine and of public health, beginning through a tiny trickle of knowledge and experience, is

destined little by little to engulf all clinical subjects and to flood the world beneath a sea of cleansing wisdom and freedom from all disease." He grants that the individual is the concern of the general practitioner and the specialist. Preventive medicine is not concerned with cure but with prevention, and it is in this sense, he says, "that state medicine must come gradually, but very surely to supersede, to engulf the medical subjects of healing."

So long as any system devised for the maintenance of the public health is contained within such scope as our distinguished colleague outlines, we can find no fault. For, as all must grant, there are certain matters pertaining to the health of the citizenry of any country that can be administered more advantageously by the government, national, state or municipal, than by the medical profession, in groups or individually. No one will deny that epidemiology, sanitation and the care of the mentally diseased, of the tuberculosis, and of the indigent sick are matters which may be said to involve more than prevention, and which yet require governmental supervision.

The history of the United States Public Health Service, from its beginning in the Marine Hospital Service, authorized by act of Congress and approved by the President in 1798, makes fascinating reading. Its evolution has been gradual, perforce, and has followed the trend of scientific medicine. Its functions now include: (1) protection of the United States from the introduction of disease from without; (2) prevention of the interstate spread of disease and suppression of epidemics; (3) cooperation with state and local boards of health in health matters; (4) investigation of diseases of man; (5) supervision and control of biologic products; (6) public health education and dissemination of health information. To such manifestations of governmental control there can be no objection, and it is sincerely hoped that no encroachments on private rights will ever be made by this splendid agency of our government.

But we are not willing to accept the view expressed by some that public health or preventive medicine has

practically no limits. We are not willing to see the entire population, with the exception of the rich, taken away from the individual physician, whether he be family doctor or specialist, and turned over to the salaried physician who, by virtue of the circumstances under which he must render his service, will not be able to devote to the individual patient the careful study that is or may be required. And when I say that we are not willing to see these things come to pass, I have in mind the interest of the sick and not the bank account of the physician. No scheme has yet been evolved of state insurance, state medicine, or whatever it may be called, that has demonstrated unequivocally the advisability of going the limit in the matter of governmental control over individual health maintenance.

Nongovernmental Paternalistic Tendencies

Aside from efforts directed toward the conservation of the public health by agencies of government, there has grown apace another form of paternalism applied not to public health but to the health of the public, if such a turning of words is permissible. The list is long and steadily growing longer of agencies, medical, quasi-medical and plainly nonmedical, which have for their object some form of medical oversight, "guidance," "education," "social service," "psychiatric social service," "case work," and what not, all directed toward the physical, mental, moral or emotional life of parents or their children, and all under the guise of physical or mental "betterment."

To what extent these agencies have followed the lead of the government, with its paternalistic monstrosities —the Volstead act and its correlated enactments, the Sheppard-Tower bill, the Newton bill and the long list of pieces of paternalistic legislation proposed or enacted— cannot be vouchsafed. After looking through the list of these agencies, one is constrained to ask what has

come over the people that makes such oversight necessary or possible. We are told that mothers have been "educated" in the care of their children until they are stampeded by the multiplicity of directions, and in increasing numbers are turning the job over to the "clinic" or "center" or whatever agency may be available for shifting responsibility, while they read the latest thriller or go to the movies.

PATERNALISM DESTROYS SELF RELIANCE.[6]

There is a group of bills prominent before state legislatures and the federal congress since 1917 which, if enacted and retained among our laws, would immediately destroy the medical profession of the United States and would undermine and ultimately destroy our republic. I refer to the group of bills which propose or pave the way for what has been called "state medicine."

The maternity bill presented to the present congress proposes by title to help states to help women by prenatal and postnatal care, regardless of financial standing or economic ability. By line the bill proposes that the federal government give money from its treasury to any state which accepts its provisions and allots a like sum of money for its purposes; the money to be spent by the state boards (to be created) under the direction of the federal board (created by the bill), the money spent being prescribed to promote the care of and provide instruction for women in maternity. The bill presented to the Illinois legislature at its last session will serve as samples of the team bills of the states. These bills widen the scope to include the care of babies under one year and they specify the employment of doctors, nurses and instructors by the state.

Analysis reveals that the presumptive basis for the proposal is that women need better maternity care than

[6] By William D. Chapman, M.D. *Illinois Medical Journal.* 40:278-81. October, 1921.

they have received in the past, that money can buy it and that tax money from the public fund properly can be used for the purpose, and that state care can be more efficient than private, competitive care.

Considering this presumption, I cite that the highest possible degree of care is limited. It must stop with the reaching of the highest possible human efficiency. No person who ever watched a women in labor will have the temerity to expect a time when one hundred per cent of all women may labor through without some fatal accident or incident. There are women in the country who avail themselves of the best maternity supervision, nursing and education in the world, renting an education early in the course of a pregnancy and keeping it on duty twenty-four hours a day throughout the period, to supervise their every action. These women do not show better mortality or morbidity figures than do their sisters of less money and healthier habits. Their education teaches them that important things antedate the beginning of pregnancy.

There is no woman in the continental United States today who cannot obtain prenatal and postnatal care if she wills. There is no government short of autocracy which can give it to her if she will not.

In a republic the use of money from a public fund must presuppose a public benefit. Treasuries, national and state, are fed by tax money. Tax money, whether it be direct or indirect, is the contribution of the individual as his share of the group expenses. Group expense in the beginning was construed to mean the necessary transaction of the public business. This construction has held until the present time with but one notable exception. In the beginning the private matter of schooling children was voted a matter of public welfare, because no agency existed which could supply instructors separately, or house the number involved. In that instance it was thought wise to keep the money account separate

from governmental expenses proper. That condition still exists. In the present instance private agencies do exist and stand ready to keep pace with all demands. No similarity of need exists.

With this in view, no reason can be cited why a charwoman in Connecticut should send money through the medium of the treasury to an oil magnate in Texas, to pay the doctor's bill of his wife. If a man or a group proposed to hire a nurse for my wife or child, I should resent it. And I know from an intimate acquaintance with American family life that craftsmen, farmers, merchants and laborers share that feeling. We have prided ourselves on our independent ability to keep out of the poorhouse and off charity lists. The huge proportions of these recent socialistic proposals and the noises of altruism made by paid lobbyists and campaigners have concealed the details of operation and have blurred the vision of many citizens who would otherwise have been quicker to resent an attempt to undermine their independence. . .

We who were raised with a horror of the poor-house, which was then the popular word for "state care," have one duty which cannot safely be left to our hired help. It is that we instill in our children an intense fear of state care, however disguised, and teach them to believe that the state care of their day is synonomous with the poorhouse of their parents and the paternal government of their children. A paternal government is not a republic. Attending to that duty, we have one consolation, and it is the thought that we may not fail. The prophets of Europe may be wrong.

That state care is more efficient than private competitive care I deny. In competition lies keenness. In its absence are standardization, ruts of routine, loss of the personal relation and lethargy. The education mentioned in the maternity bills is most desirable, but it also is already available. All of the so-called non-technical instruction in these matters can be printed in a very small

pamphlet, such as has been for years distributed with gratifying results by the health departments of Illinois and other states. All of the rest of it is the practice of medicine; when symptoms arise the case has become one in which the physician observes, correlates, interprets and treats. It has become a very individual and a very private matter, and one whose ends are best attained by the keenest of competition. In all state service competition is out and individualism is frowned upon, seniority rules and workers are prone to become lethargic. In state service it is a classic that good men outgrow their jobs and quit, while poor or indifferent men never resign and seldom die. A new law cannot change those things.

State medicine killed the medical profession in Germany. There was a time when the physicians of the world went to Berlin for the best advanced thought. Since German doctors empanelled in the service of the government under the workings of the Compulsory Insurance Act, nothing new has come from Germany except two laboratory results, one of which was the work of a chemist who had not studied medicine. Today the United States is the world center of medical education. The keen urge of competition is the lifeblood of progress.

Compulsory health insurance was the first of the group to appear in this country. It came to us as German propaganda before we entered the war and was not recognized as such until given light of subsequent developments. Synchronously with the proposals that it be adopted by the allies this measure was offered to us and in 1917 it appeared, almost without warning, in twenty-two state legislatures. It was sponsored by the American Association for Labor Legislation, an organization whose membership lists showed only the thinnest sprinkling of employers of labor or employees or doctors, the three groups immediately affected. None of these groups had recognized such a need for this country. The proposal made much headway before any were equipped to com-

bat it, for it was pushed by efficient full time workers and by lobbyists who were spellbinders. Money for its pushing seemed at that time and seems now plentifully easy.

Health center and state clinics where people who are not paupers may receive free treatment, are obnoxious to the American citizen who wishes to pay his own way but are hailed with acclaim by immigrants who have been taught to regard a government as a father. These things, together with the various other agencies practicing medicine, have made inroads on the income of the medical profession. If it continues, there will come a time when service will suffer and when good men will desert the profession. Some doctors would be happier cleaning fish than working under a state panel on salary. In Germany panel doctors have recently been making professional calls at eight cents per visit, and crowding in enough visits each day to continue to live. I cite with confidence that such a visit is not worth eight cents to the patient. And so it has been said that in the last decade before the war, the German people received the poorest medical attention known in any civilized country.

In matters of state medicine let us see clearly which are state matters and which are private. Preventive medicine is a state matter, inasmuch as it protects one man from his neighbor's contagion. It properly carries police power, to the end that one man may not endanger his community. Curative medicine carries no menace for each family in a republic. If there are reasons why the state should buy medicines and purchaseable services for its citizens, then there are the same reasons why the state should buy groceries and do plumbing for its citizens. The line between the preventive and the curative is distinct and will not lead us astray.

Each citizen may carry voluntary insurance in existing companies, against the expense of illness, if he wills. That is prideful, American and right.

SOME OF THE SOCIAL PROBLEMS OF MEDICINE[7]

Medicine is, in fact, particularly exposed to the dangers of socialization, because the projects of socialism that contain the first acceptance are those that have to do with health and physical welfare. There is an evident tendency now to appropriate medicine in the social movement; to make the treatment of the sick a function of society as a whole; to take it away from the individual's responsibilities and to transfer it to the state; to turn it over to organized movements. If this movement should prevail to its logical limits, medicine would cease to be a liberal profession and would degenerate into a guild of dependent employees.

Now, this is a gloomy picture for a celebration, but, to paraphrase a statement of Birrell's it is better to entertain a gloomy fact than a cheerful fiction.

And there is another side to this picture. There are influences which will in time, probably, first check the socialistic trend and then cause a reaction. Probably this will come only after sad experience and at high cost; but society gets on only with such penalties.

In the first place, the effects of a natural law, such as that of the survival of the fittest, cannot be greatly modified nor long set aside by the puny efforts of man.

In the next place, the machinery for all these socialistic and paternalistic enterprises will in time become so large and unwieldly that it will be impractical and fall to pieces. When, in addition to the ordinary machinery of government, we add the new machinery for running the mines and the railroads and the telegraph and the telephone and the wireless, for the regulation of capital and

[7] By William Allen Pusey, M.D. in his Presidential Address to the American Medical Association, at the Seventy-fifth Annual Session, Chicago, 1924. *Journal of the American Medical Association.* 82:1905-8. June 14, 1924.

industry, for the stabilization of industry, for employment insurance and health insurance, for old age pensions, for socialized recreations and socialized neighborliness, for socialized health education and programs—when on top of these you pile the organizations for keeping the people from using opium and cocain and alcohol and doing other things that are not good for them, for enforcing all sorts of laws that prohibit some of the population from doing things that another part thinks are wicked, for socialized nursing and medical care, for taking over obstetrics, child welfare and venereal diseases, for the care of the injured, crippled and defective—when these activities, nearly all of them temporarily good in themselves, have developed to a certain point, the burden will become too great. The men taken from productive occupation and private enterprise that will be required to man them will be such a large proportion of the population that, sooner or later, the social fabric will give way. There will not be enough of the population left for production to take care of the administrators; and a reaction, if not a crash, will come.

This is no imaginary situation. Attention is constantly being called to it. As Beveridge points out, even now there is one government employee for every twenty-one adults and, according to the National Industrial Conference Board, every eleven workers over sixteen years of age support one government worker. In view of his wise statesmanship, it is not surprising, but it is a reason for encouragement, that President Coolidge has opposed this trend in his definite stand against federal support of such activities.

In the next place, and most hopeful of all, society is usually saved from its own carelessness—except when a cataclysm occurs—by the persistence of a minority element which, through character, intelligence and force, is able ultimately to exercise a controlling hand in the direction of affairs. If civilization is to be saved from the effects of a socialized mediocrity, it will be by the presence in the community of this influential minority.

How shall we in medicine oppose this destructive social trend? By making ourselves, in the first place, a part of the enlightened minority that is the salvation of democratic government—that leaven which has caused the gradual advancement of mankind; next, by making our standard sound public policy; by being alert to the socialistic dangers to medicine and by aggressively opposing them; by opposing, as vigorously as can be done, the various governmental projects for practicing medicine, and the efforts of organizations, public and private, including medical schools and hospitals, to go into the practice of medicine as a business. These things are already being done. They are fundamentally wrong; they are throwing to the winds the sound traditions of medicine that have developed from long experience and that from experience have been found to be essential to medicine's character and progress. The profession should bring all the forces of its influence to their opposition. It might well adopt as its motto here the words of Tennyson's Ulysses: "Strong in will, to strive, to seek, to find and not to yield."

These are but examples of how we can oppose the socializing trend in medicine. The essential thing is to be alive to these dangers and consistently to oppose movements that are unsound, regardless of their temporarily seductive character; for, as Spencer says, "If amid all those compromises which the circumstances of the time necessitates, or are thought to necessitate. . . if nothing beyond the exigencies of the moment are attended to, and the proximately best is habitually identified with the ultimately best, there can be no true progress."

It is, to take Spencer's phrases, the acceptance of proximately best measures, instead of following the sounder, harder course of working for the ultimately best measures for society, that is the danger to medicine, because it leads to medical socialism. The tendency has already resulted practically in medical socialism for the middle classes of Europe, and in doing so it has brought

about a situation that is neither sufficient nor satisfactory for the public or the medical profession. . .

Many of medicine's problems of the present day are equally bound up with the social welfare, but these are having constant emphasis and need no lengthy statement here. Because of their importance and difficulty, one sort of these problems may be briefly referred to. These are the problems involved in the education of the public in medicine and in regard to medical frauds and fanaticism.

The education of the public in medicine is a long way from complete, but it is being faithfully undertaken by scores of agencies. The audience is for the most part receptive—not to say eager—and the difficulties, as far as the intelligent public is concerned, are chiefly those of the size of the task and the complexities of the subject. The hardest problem, because of the ignorance or the mental vagaries of the groups that must be reached, is that of educating the public concerning medical frauds and cults. . .

But, after all is said about the other problems and responsibilities of medicine, the greatest of these is the old homely one of treating men that are sick and injured. We hear so much now about preventive medicine, about medicine's new social responsibilities, that this old responsibility is failing to stand out in proper proportions. Prevention is an important function of medicine, and will doubtless become more so; but it is altogether likely that it will never be its chief function. We would like to see the day when physicians were not needed, but it can be confidently predicted that no such happy day will ever come. Sickness and injury will inevitably remain part of the lot of man. Carry our discoveries to the utmost limit, man is still a machine that will get out of order, will be injured and will ultimately wear out. As long as that is true, there will be need for the personal physician to take care of the individual patient. For this service, thousands of physicians will be needed where hundreds can be usefully employed in research and preventive

medicine. These are the men on the firing line; the battle for the relief of suffering depends on them. And the efforts of society, as of this Association, should be dedicated to the welfare, and development in training and character, of these men, engaged in the workaday duties of caring for the sick, wherever they are scattered over the face of the earth. To foster the competence of these men is the greatest social responsibility of mdicine.

SOCIALISTIC TENDENCIES IN MEDICINE[8]

It is not wise for a state to pauperize its people, nor is it fair to the medical profession to deprive it of its legitimate livelihood.

The man who takes up the study of medicine in New York state must spend, after he leaves high school, the equivalent of two years in college and four years of the hardest kind of study in a medical school, and at least one year, or more often two years', internship in a hospital. Before he can begin to earn his living, he must spend seven or eight years in study and work.

The physician has always been too busy looking after the needs of his patients to give much time to his own interest. As we view the changed conditions in the last few years, unless he awakens to the drift of the tide there will soon be little inducement for a young man of real ability to enter the medical profession. Even now, after he has finished his hospital internship, he finds that the cost of opening an office and waiting for a practice is appalling. If he accepts a municipal or a state position, which gives him an income of $500 or $1,000 a year, it will help to tide him over a few years. Habits are easily formed. He receives a slight increase as years pass, but he loses the courage to break away and strike out for himself. His ambition and incentive have been lost. The young physician, ambitious to rise in his profession, and realizing that only by hard work and conscientious study

[8] From article by James A. Gardner. *Journal of the American Medical Association.* 79:513-16. August 12, 1922.

can he accomplish this end, finds that, while he is improving himself, he incidentally is making himself a better public servant. If his incentive and ambition are taken away by some government job, will he be any different from the clerks that we find now who have held the same position for years, and who, if they lose their positions, are unable to support themselves?

Throwing aside all consideration of the medical profession, a very serious outlook confronts us. Without realization of the outcome, a dependent class is being formed, a class which will next demand other benefits without pay or effort. It is my belief that the time has come for action on the part of physicians who are proud of their profession. We have been quiescent and complaisant, until the political doctors and doctor politicians have gained a foothold which will be hard to break. They make an insidious plea for public support and a seductive argument to gain the good will of honest and fair-minded people. They have patronage which they distribute judiciously among those whose help may be desired either within the medical profession or among outside political or other influential circles. The medical profession cannot be free and uncontrolled with these medical machines, powerful and active with their advocates and defenders, spread over a city or a state, with jobs to distribute and with power to destroy a private practice built up after years of struggle and faithful service.

It will not do to scoff at the danger or minimize its importance. In its inception, it was harmless. In its spread, it has become a menace to medical men in their standing, ideals and progress. If we do not destroy socialism in medicine, it will destroy us.

A FAMILY DOCTOR SPEAKS HIS MIND[9]

There are two glaring fallacies frequently set forth by those who advocate group-medicine as a substitute for the individual family doctor. The first is that all patients

[9] From an article by Wingate M. Johnson. *Harper's Magazine.* 158: 50-6. December, 1928.

who consult doctors need exhaustive examinations to find out what is the matter with them. The second, that modern medical skill can solve all medical problems—that "it has taken its practice from the realm of guesswork to the realm of certainty."

While it is true that some medical problems are very complicated, it is fortunate that most of them can be solved with comparative ease by any competent, well-trained medical man. I know of no better way to prove this statement than to take up, case by case, my last full day's work before beginning a vacation.

The day's work began—not including the numerous telephone calls before I left the house—by witnessing the removal of a diseased appendix and gallbladder from a man who had had attacks for some time, so typical that it was not necessary to have an X-ray examination to confirm the diagnosis. In the same hospital I visited a man eighty-four years old with the classical symptoms of arteriosclerosis. Not all the clinics in America could add many years to his life.

My next three cases were children with influenza. Two were quite typical, but the third was of the intestinal variety which closely simulated appendicitis. Long clinical experience, aided by a blood count made for me gratis by a hospital technician, enabled me to recognize it.

The next patient was a young school teacher with influenza. Surely the intensive training all medical men have had in that disease since 1918 should insure its recognition without the aid of a group of diagnosticians.

At this point came an urgent call to a good friend and patient, who died suddenly of angina pectoris before I got to him. Within the past two years he had visited two of the best-known and most highly rated clinics in the country in search of cure. They changed neither my diagnosis nor proposed treatment. Any good general practitioner in the country could duplicate this case many times.

Following this I saw a patient with influenza, then one with tuberculosis (easily diagnosed by physical examination, but confirmed by a sputum examination, done by my accommodating technician friend). She is improving under the standard treatment of rest, fresh air, and good food. If any clinic can improve on this combination, I am open to suggestion.

In another hospital I visited a man whom I am treating for peptic ulcer—a diagnosis made clinically, but confirmed by the X-ray. In the same hospital was a woman with arthritis involving her knee and wrist. Her case has been a puzzling one, requiring the aid of the laboratory, X-ray, and an orthopedic man in consultation.

My next call was to see a baby with a fermentation diarrhea. The last patient before I went to the office was a man with a very sore mouth, due to Vincent's angina, or "trench mouth." He had been to a clinic for examination before I saw him though, I had seen and diagnosed numerous similar cases, with laboratory aid, and had treated them with some success. I admit, however, that he brought back with him an idea about treatment which was a new method of applying an old principle. This I found helpful in his case, and I expect to apply it to future cases.

In the office I saw first a woman with a deformed toe, whom I referred to an orthopedic man. Next came a young man who complained of "indigestion" and "nervousness." His appendix had been removed, eliminating the chief organic cause of indigestion, and his symptoms were very indefinite. He had recently begun a sedentary occupation after being accustomed to regular exercise. It required no clinic to tell him what to do. Then came a girl with an ingrown toe nail; a child with tonsillitis; another with *impetigo contagiosa* (an easily recognized skin infection); a woman with pain in the muscles of her back, perhaps due to obviously infected tonsils; and two children for vaccination. Three insurance examinations completed my office work for the day.

After the evening meal, besides rounds at two hospitals, my only call was to see an old lady with a small but painful tumor, whom I referred to a surgeon.

This is a faithful summary of one day's work, typical except that I rarely escape with only one evening call. By the way, our advocate of the group-medicine idea of family practice neglected to say what happened to a patient seized in the middle of the night with kidney colic or acute appendicitis. The operator at the clinic telephone would probably be off duty then, but somehow such attacks have an inconvenient way of coming at unearthly hours.

I have gone into tedious detail as the best method of showing that the usual run of cases coming to the general practitioner are not so complicated that the services of a whole corps of specialists are needed for their diagnosis and treatment. With the possible exception of the young lady with the pain in her back, the process of going the hopper of a clinic would have been an utterly needless expense for all these patients. Obscure cases which tax every resource of modern medicine are occasionally encountered; but what conscientious physician will refuse to recognize his limitations?

A second fallacy held by advocates of group practice is that modern medical skill can solve all disease problems. After having seen in a number of cases the most highly-rated clinics in the country fail to reach correct conclusions, I realize afresh that Hippocrates "knew his onions" when he said "Experience is fallacious and judgment difficult."

Let me cite three cases in proof of my contention. A few years ago a good friend and patient of mine went to one of the most celebrated clinics in America for examination and treatment. In writing the director of the clinic, I told him that the patient was one of the most typical cases of cario-vascular-renal disease (practically the same as arteriosclerosis) I had ever seen. In due time an exhausive document came from him, recording

all their findings. He regretted that he could not agree with my diagnosis, giving it as his opinion that there was no trouble with the heart or kidneys, but that the patient's sole trouble was a secondary anemia. He did not state, however, what the anemia was secondary to. After being kept in bed for a month on forced feeding, which he did not need, the patient was sent back with directions for me to continue daily hypodermic injections of the then-favorite sodium cacodylate. Within a month I had the grim satisfaction of seeing my diagnosis confirmed by repeated fragments breaking off the walls of his circulation—one rendering him blind in one eye, and several others going to his lungs. One proved fatal.

Another case was that of a woman who, after suffering for several months with headache and frequent attacks of vomiting, had been taken to a famous clinic in a large city, where she was "studied" for two weeks. Her gallbladder was removed with her appendix and she was sent back home. No relief was obtained, however, so she was sent to one of our hospitals. There the discovery of a double choked disk gave the clue to a brain tumor, from which she soon died. When I wrote the surgeon who had operated on her of this finding, he replied that he was very much interested to learn of the new development in her case. This reminded me of an incident of my hospital interne days. One of our classmates, who was serving in another hospital, paid us a visit, during which he boasted of the large number of major operations he had been allowed to do. After he left, one of our number expressed the feeling of us all when he said, "I don't mind listening to his lies, but I do hate to think that he thinks I am sucker enough to believe him." I hate for this surgeon to think I believe that the tumor developed after the patient left him.

A good friend of mine, also a general practitioner, sent a patient with a history of repeated heart attacks, to a celebrated clinic. The man came back with a letter from the head man of this group, stating that he found

nothing wrong with the patient's heart, and considered the attacks purely nervous—in other words, hysterical. The next day, however, the patient was so inconsiderate of the great man's reputation as to drop dead in an attack.

These cases might be multiplied but they are enough to show that no one man nor group of men has a corner on knowledge. By way of contrast to the arguments of the group-practice advocates, let me quote from an article in a recent *Journal of the American Medical Association,* by one of the greatest medical teachers in America:

> The greatest difficulty confronts us in attempting to determine whether a given group of symptoms is functional or structural in origin. These symptoms and even the laboratory observations may be the same in two cases, yet one may be organic and the other functional. Every surgical clinic affords proof of the errors arising through this mimicry, and every practicing physician has regretted experiences that prove to him the fallacy of the ordinary criteria of disease. What can help us in such a doctor's dilemma? Perhaps that heaven-born gift, intuition, the subconscious psychologic insight which comes to us when we study the patient personally. It is because it tends to neglect that subtle insight that I am not favorably disposed to the hopper method of studying cases which obtains in certain clincs. Such a method precludes the utilization of the sixth sense.

Another objection to the clinic method of handling patients is the loss of the sympathetic bond between patient and doctor. To the clinic doctor the patient is only a problem; and the scientific attitude toward him is apt to be developed to such a point that his emotion side is forgotten. . .

Still another argument against the group idea is that there is great danger that in the multitude of counsellors there will not be any one man to feel actual responsibility for the patient as will the individual doctor.

It seems, though, that the doctor has been the target for more attacks than anyone else. There must be some reason for the almost sudden change in the attitude of the people toward the natural guardians of their health. I cannot help but feel that the rapid multiplication of specialists, real and self-styled, and the commercialization

of medicine by group practice are at least partly to blame. The change may be for the best interests of all concerned—but there are many who are not convinced that it is. It is true that the present fashion is to emphasize the importance of the specialist and to minimize the general practitioner. The specialists complacently accept this arrangement, and so do many practitioners. But why should they? Does it not require just as much brain power to minister to the whole body as to treat a section of it? And does it not require as much personality to keep a family satisfied as to use the magic word "specialist" as an aid to confidence? It is true that close and continued application to one part of the body or to one branch of medicine brings increased skill therein, but it also tends to give a distorted view of the whole organism.

Many thoughtful observers believe that the wave of specialism has passed its crest, and there are signs that the general practitioner is coming back into his own. The highest possible authority on the subject, the Committee on Medical Education of the American Medical Association estimates that a good general practitioner is capable of handling from 80 to 90 per cent of the illness for which patients seek medical advice.

THE PAUPERIZATION OF MEDICINE[10]

TO THE EDITOR: We hear on all sides the discussion of the question of social medicine, state medicine, or whatever name this new bogy to the medical profession may be designated. This problem is treated like some sinister demon of phantomlike nature, which, hiding in the dark, will inevitably be heard and soon seen or felt in all its terrors. That it will be of grave danger both to the medical profession, as well as to the general public, seems to be the accepted opinion. The profession

[10] Letter from Dr. S. E. Barnett to the *Journal of the Michigan State Medical Society*. 20:489. November, 1921.

has even gone so far as to hold protest meetings and appoint committees to combat the evil.

But that is neither here nor there. The trend for a good many years has been for the "pauperization of medicine," and not as is so sweetly expressed, the socialization, and I contend that the latest step, this so-called "state medicine" is but another step in that direction.

Just glance at what the regular practitioner of medicine has to contend with in order to make a livelihood for himself and dependents, as a reward for having devoted the better portion of his life in perfecting himself for his career. The array of competition is astounding. It is to be wondered that he can exist at all. In the first place, state, county, and city departments of health already are practicing medicine to a large degree. In the city of Detroit, the city has the largest genito-urinary practice in its territory. It has the largest eye, ear, nose, and throat practice, including operative work, in the city. It has a free maternity hospital and baby clinic; it does first aid and medical treatment in the schools, etc. What is all this? What is the cause and purpose? The primary function of the health department should be in preventive medicine and sanitation. If this includes the removal of tonsils or the taking care of confinement cases, etc., there is no reason why the private physician isn't capable of doing the work instead of socializing it by the city. In the same manner in which the poor and needy get city checks and allowances for food and clothing and go to their own private clothier or grocer, so in like manner should the patient be enabled to choose his own family physician or the specialist as required. Not only does the city practitioner have to compete with an already organized and functioning state, county, and city medical practice, but with many other boards, bureaus and clinics. Nearly all hospitals have so-called free clinics, and while the majority of cases attended are beyond question, deserving and creditable, however, is

it not pauperizing the people as well as the profession to dispense free medicine in this manner?

The public should vote certain grants for this class of people, so that the physician should receive compensation for his services, and then the patient would know that he is under no obligation to the doctor or to the hospital. Besides the hospital clinics, the doctor must compete with the so-called welfare and social center clinics, with lodge and fraternal doctors and what not. More recently such hospitals as the Henry Ford and the U. of M. are practicing medicine and surgery with their own staffs in open competition to the entire medical profession; the first, a private institution doing no free work, and the second, a state institution taking pay cases.

NATIONAL HEALTH INSURANCE[11]

The present scheme of National Health Insurance in this country originated with the Act of 1911, described as "an Act to provide for insurance against total loss of health and the prevention and cure of sickness, and for purposes incidental thereto."

While the motives alleged as promoting that legislation were admirable, the actual provisions of the Act fell far short of securing the achievement of the purpose cited. It is unfortunate that political considerations have continued to influence the operation of the Act; they have rendered National Health Insurance, as I maintain, the illusory thing it still is, and have largely contributed to the profund dissatisfaction both of doctors who operate the Act and of patients who are its victims. While the principle of National Health Insurance is beyond criticism, and is accepted nowadays as entirely proper and necessary, the means actually adopted are very open to controversy. The opinion is widely prevalent that an equivalent expenditure otherwise directed might produce a much greater benefit to the public health. . .

[11] From article by E. Graham Little, M.D., F.R. C.P., M.P. *Nineteenth Century.* 104:583-94. November, 1928.

The panel practioner is . . . hindered even in the exercise of his capacity, for he is overruled by countless bureaucratic regulations and encroachments upon his professional liberty. Those encroachments have been still further and much more seriously increased in the past twelve months by the operation of a very remarkable agreement which was concluded between the Ministry of Health and the dispensing chemists last year. In that year, 1927-8, the total cost of medical benefit was 8,050,000*l.*, of which sum 5,999,000*l.* was appropriated for the professional remuneration of the doctors working the Act. The Drug Fund, as it is called—that is to say, the amount produced by the allotment of 2*s.* 10*d.* for "drugs" per head for each person—totals over 2,000,000*l.* Prior to 1927 the Drug Fund had always been overdrawn. In 1927 the Ministry of Health, no doubt anxious to avoid the recurrent unwelcome demonstration thus afforded of the essential insolvency of the Drug Fund, concluded an agreement with the dispensing chemists by which the Drug Fund, now for the first time strictly limited in amount, has to provide a working profit for the chemists first, and the sum available for drugs and appliances for the insured is rigidly limited to what is thus left over. All the great medical organizations stoutly declare that they were never consulted as to this agreement. A leader in the *British Medical Journal* of September 29, 1928, describes it as "dangerous and undesirable." The Conference of Panel Committees held last year (October 1927) recorded a unanimous resolution that the agreement was "against public policy." It would seem clear, therefore, that this agreement was forced upon the great body of panel practitioners without their knowledge or consent, a procedure which is surely the very worst method of securing the cordial co-operation of the men who are responsible in the last instance for the working of the Act. Obviously it is only equitable that, inasmuch as the chemists are now responsible for overdrafts upon the Drug Fund, they should have some

means of controlling expenditure under this fund; machinery has accordingly come into existence which enables the chemists to exercise this control; and the chemist is exhorted by his official societies to do so. . . It will be seen that the chemist is here encouraged to submit a *secret* report upon the doctor's prescribing!

The gravamen of my criticism is that a body, the insurance committee, overwhemingly lay in composition, is thus in a position to judge finally a professional man upon his professional practice, a subject of which the large majority of members of that committee are necessarily ignorant. Public opinion would, I think, condemn this system as emphatically as medical men have condemned it. Thus *The Times* in a leader of August 24 last, commenting upon these features of panel practice, said:

> His freedom to treat his patients according to the dictates of his knowledge and experience is a doctor's most valued and most valuable possession. To compel him to justify or to explain the exercise of that freedom is to limit it in a way which may easily become dangerous to his patients.

I have said that the trend of medical practice at the present time is in the direction of improved means of diagnosis and the provision of modern methods of treatment which follow upon that diagnosis. In those modern methods the "bottle of medicine" has receded further and further from its ancient position of authority, but in panel practice it is the "bottle of medicine" which is often the only means of treatment at the disposal of the panel practitioner, and, as I have shown, the contents of that bottle are ultimately determined, not by the prescriber's desire, experience or knowledge, but by the considerations of economy which present themselves to the chemist when he dispenses the prescription, for by the bargain of 1927 the chemists are directly and financially interested in dispensing only the cheapest medicines. One of the most mischievous aspects of this position is that the public are encouraged to place continued faith in the

"bottle of medicine," the contents of which are mostly ineffective; the waste entailed by this valueless drug consumption approximates 2,000,000*l.* a year. Moreover, in very many cases still more precious time is wasted in this useless treatment, when, if the case were properly diagnosed and efficient treatment given, cures might result which with this waste of time become impossible by reason of the advance of disease beyond the limits of medical intervention. Surely diagnosis ought always to precede treatment! In the enormous majority of cases of panel practice treatment is given, and continued for long periods, upon a diagnosis which is necessarily extremely inadequate, and therefore not infrequently erroneous. The sole bulwark which has prevented the present insurance system from crumbling to the ground is the assistance now afforded to insured patients by the voluntary hospitals. This assistance is not in any way secured to the patients by the Act; indeed, it is essentially fortuitous in its incidence, and largely gratuitous, on the part of the hospitals. Evidence placed before the Royal Commission repeatedly drew attention to "the fact that the treatment of insured persons by insurance practitioners is incomplete because it is not satisfactorily linked up with provision for treatment in hospitals." It was emphasised that "owing to various causes no payment whatever was made from insurance funds in respect of a large proportion of those insured persons who receive in-patient treatment in hospitals; that even in the case of those who made contributions the contributions formed only a part of the average cost per bed; that no payment was made in respect of the general out-patient work." The experience of a group of hospitals in Sheffield, as reported to the Commission, is illuminating. In 1923 the cost to those hospitals of treatment of insured persons was 28,870*l.*, while the total amount received from insurance funds for the same period was only 4300*l.* But even this assistance, which is voluntary at the present

moment, is in danger of being disturbed if the voluntary hospitals come, as is now so seriously threatened, under bureaucratic control. In that event the most—and, in my opinion, indeed the only—efficient medical benefit under the Insurance Act would disappear.

STATE MEDICINE [12]

During the year that has just passed, several events have happened that are of interest and importance to the profession. Among the most important of these may be mentioned the formation of the Public Medical Service Association of England, which aims at establishing a universal medical service by the government available to the entire population. The present National Health Insurance Act applies only to what is called the working class and a section of the middle class earning small salaries who are regarded as being unable to pay for necessary medical service. This service under governmental administration is to be made available to all irrespective of ability to pay. It is a direct attempt to extend socialism and would result in a complete socialization of the medical profession. The idea is that health is of such vital national importance that the question of one's ability to pay should never arise. A bill to this effect has already been introduced in the House of Commons, and it is admitted by the secretary that the movement will be opposed by the medical profession; but when the legislation is passed the profession will have to bow to the inevitable as it did when the National Health Insurance Act was passed. In the hope of counteracting this attempt by the government to socialize the medical profession, the British Medical Association has come forward with a proposal to furnish adequate medical service to all the people, and in the supplement to the *British Medical Journal* of April 26, 1930, the complete details of the

[12] From Address of President M. L. Harris to the House of Delegates, American Medical Association, June 23, 1931. *Journal of the American Medical Association.* 94:2070-1. June 28, 1930.

Association's proposal for a nation-wide medical service are clearly set forth. Here is an actual illustration of what may be expected to happen to the medical profession when it loses control of its own business.

A similar serious situation has already arisen in Belgium and the mass of physicians there are complaining bitterly of the inability to obtain a sufficient number of patients who pay to enable them to earn a living for themselves and their families. The establishment in Prussia of an occupational tax levied on the practice of medicine has brought consternation to the ranks of the medical profession, who already had found it almost impossible to earn a decent living under the *krankenkassen* system. The occurrence of these events, which are at present taking place before our eyes, again brings me to call attention to the economic situation as it exists in this country, where medicine is under siege. Medicine is being besieged on every side by forces that are constantly growing stronger and stronger, and unless some defensive effort is made to break the siege the profession must eventully capitulate and become socialized and become employees of the state. I therefore respectfully urge that this body give thoughtful consideration at this time to the plan which I suggested last year of having the county medical societies incorporate and organize for business purposes and to establish medical centers owned, controlled and managed by the profession where all classes of persons who are unable to pay regular fees to their own physicians for medical care can be given the highest type of medical treatment at prices within their means. The establishment by the profession of these pay medical centers for the class of patients already mentioned, to take the place of the numerous free clinics, and the development of these centers to their fullest possibility based on the full recognition of the principle of cooperation and collectivism in matters pertaining to the welfare of the profession as a whole, will do much toward maintaining

professional independence of thought and action, and it is infinitely better to do these things voluntarily than to be forced to yield to coercion.

It is unwise to put this matter off from year to year while the siege of medicine is drawing its lines tighter and tighter.

BRIEF EXCERPTS

Too much centralization of government is a dangerous thing. The practice of unloading personal responsibility on swivel chair autocrats and remote bureaucrats in Washington must be stopped if the American people are to retain their self respect which is the basis of self reliance and self help.—*Illinois Medical Journal. Ja.* '23. *p.* 6.

The policy which the government has adopted with respect to the medical, surgical, hospital, nursing and dispensary care of veterans is a policy that places the federal government in competition with private practitioners and private hospitals with respect to such service. —*Bureau of Legal Medicine and Legislation of the American Medical Association.*

It is clear that our civilization is committed to a sort of socialism to the effect that the economically fit and competent shall take care of the weak and inefficient. It is an unconscious endeavor to set aside the law of natural selection and to counteract nature's cruel but salutary process of eliminating the unfit.—*William A. Pusey in Presidential Address before the American Medical Association.* 1924.

Nor is pauperizing the public going to be of any particular benefit to the medical profession. No incentive to work toward greater efficiency, for once installed in a job and having sufficient "pull" to hold it, why should the doctor worry about a trifle like efficiency?. . . And the

pauperized public will suffer because of such a condition, for it will not be given attention by men of true efficiency. —*G. L. Seross, Editor of the Western Medical Times, in the Medical Record. Mr.* 26, '21. *p.* 522.

The real job of the medical profession is the extension of knowledge of what the medicine of today is doing and can do in the future, and this must be done by collective effort. . . Now failures as a profession are the failures of individualism. Medicine's place is fixed by its service to mankind. If we fail to measure up to our opportunity, it means state medicine, political mediocrity and loss of professional ideals.—*William J. Mayo, in the Journal of the American Medical Association. Ap.* 2, '21. *p.* 921.

To insure the permanency and success of the family physician . . . the profession as a whole must stand united on the principle of the domiciliary visit, the close and intimate contact with family life, the primary service to the ills and distress of the social structure. All proposals, all fads of paternalism or socialization which would destroy or interfere with such relationship or with the freedom of the public to choose its individual medical service are fallacious and must not be permitted to materialize.—*Wells Teachnor, in Presidential Address before the Ohio Medical Association.* 1922.

Doctors individually and collectively must cease to give sanction to the plans of various uplifters which though ostensibly altruistic, are in reality fraught with danger to the body politic aside from degrading the medical profession by exploitation of its ability and skill in relieving human kind. . . Medical men everywhere can be counted upon to render service to the indigent and poor without money and without price, but if they are to attain the highest point of efficiency and service to suffering humanity their individualism must be preserved

and the rewards for their services protected.—*Journal of the Indiana State Medical Association. Jl. '24. p.* 224-5.

Germany is experimenting with a relief program which, though it incorporates the principles of our own public clinics, goes much farther in the direction of social welfare. The *Stadtkassenarzt* as the state physician is called, serves the masses. He is at their beck and call, at any time during the day and night, free of charge. And what is the result? A positively amazing recourse of people who, on the one hand, develop manias regarding their health, and on the other force the physician to concern himself with bodily disturbances which would remedy themselves if left alone. It follows that doctors soon grow weary, cynical and pesssimistic. The ardor of a calling to serve and heal is chilled in them. One by one they turn into mere functionaries who despair of their own future and work callously.—*Commonweal. Je.* 12, '29. *p.* 144.

In brief we believe that medical organization has and must continue to base its policies on present and future public benefit; and as a corollary to this fundamental principle we are convinced that scientific medicine must continue without excessive restriction or destructive interference as an independent, self respecting, competitive profession.

Medical organization must, therefore, continue to represent the great majority of legally qualified reputable physicians in private medical practice; and must neither be dominated or coerced by appealing but unsound theories of paternalism and social welfare in the field of public health.—*From Report of the Committee on Public Policy of the Ohio State Medical Association. Ohio State Medical Journal. My. '27. p.* 388.

Physicians are now embarked on a permanent program of cooperation in social work, and willing to proceed as

rapidly as the ways and means are developed. The recent program for enlarging the activities and the library of the New York Academy of Medicine, which has in the past done such notable work in the medical social field, is an outstanding example of this. There are only a few dangers, as I see the situation, and the chief danger among these is that the public will insist on too rapid progress, and will cast aside the vitally essential personal equation of doctor and patient. The success of medicine in future even more than in the past is dependent on that complete understanding and sympathy between patient and professional worker which has been the glory of medicine and nursing and is now being established as a tradition in social work. All organizations making for efficiency and true economy of personnel and money must be built around this principle of highly prized personal service by professionally trained and mature men and women who posess sound judgment, resourcefulness, and such liberty of action as is requisite for case work in the larger meaning of that term.—*William F. Snow, M.D. National Conference of Social Work, Proceedings.* 1923. *p.* 58.

Are we reduced to the necessity of accepting as inevitable that the old order is passing; that we can no longer produce physicians to go out and do the old time, everyday work of practicing; that we cannot change a course of ours whose direct trend is toward the day when service for the individual of ordinary means can be furnished only through some sort of industrial or socialized expedients; that in the rural communities there is no way of furnishing physicians of the new generation except by changing their economic and social conditions? Is there not some other way?

I raise the question: Is the medical profession so sure of the wisdom of the present standards of medical education toward which it is striving, and of the quality of that medical training, that it cannot consider any alteration

in medical education which might remedy the situation by supplying the people with physicians, who would be willing to practice medicine as we have always done and as the older generation is now winding up its career in doing?

I have no inclination to criticize the work that has been done in the elevation of medical education in this country. I recognize the necessity there was for it and the courage and zeal and public spirit that was required to bring it about. I do, however, urge that, in pursuit of our ideals of scientific medical training, we have reached a point where we must give consideration to these results.

In this situation, instead of unconsciously assuming that our present standards of medical education are sacrosanct and suggesting that everything else be changed instead of it, would it be contrary to public policy to have the universal degree in medicine one which would represent an adequate training for practitioners of medicine, but which would not be exacting beyond all other professions in time? I believe that such a course is feasible. . . —*Dr. William Allen Pusey. Journal of the American Medical Association. Je. '24. p. 1960.*

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